Office of the Inspector General
For the
Department of Mental Health,
Mental Retardation
And Substance Abuse Services

Semi - Annual Report
October 1, 2002 – March 31, 2003

May 30, 2003

To the General Assembly of Virginia:

I am pleased to forward the Inspector General's semi-annual report on her inspections of mental health and mental retardation facilities in Virginia. The independent oversight offered by the Inspector General remains an important feature of our efforts to improve behavioral health care in Virginia.

This report contains an overview of the Inspector General's reports during the past six months as well as outstanding recommendations of the Inspector General. I am pleased that the Department of Mental Health, Mental Retardation, and Substance Abuse Services continues to make progress on improving patient care and safety. The Inspector General's recommendations have been an important part of this process.

As Virginia embarks on am ambitious program of mental health reform, the Community Reinvestment Initiative, the work of the Inspector General's Office will remain a vital part of our system of continuous quality improvement. I look forward to working with the Inspector General and with the General Assembly as we continue to move forward in reform of behavioral health care in the Commonwealth.

Sincerely,

Mark R. Warner

MRW/wlm

COMMONWEALTH of VIRGINIA
Office of the Governor

Anita S. Everett, M.D.
Inspector General
to the Department of Mental Health, Mental Retardation
and
Substance Abuse Services

May 30, 2003

To the General Assembly of Virginia:

I am pleased to submit for your review the semi annual report for the period of October 1, 2002 – March 31, 2003. This report reflects the activities of the Office of the Inspector General over this six-month reporting period. The Executive Summary, Chapter One and Two briefly summarizes the activities of the office over this six-month period. Chapter Three includes the findings and recommendations from reports completed within this time frame and Chapter Four outlines the recommendations made by the OIG that have not been resolved as of September 2002. 100% of all active findings are monitored until resolved. This report in its entirety can be found on the OIG website at www.oig.state.va.us.

This office has been instrumental in stimulating a number of changes that have increased the quality of care within the facilities operated by the Commonwealth of Virginia for individuals with serious mental illness and mental retardation. We are proud to be of service to this often disenfranchised and vulnerable group of citizens. It is a profound function of government to provide for those who are incapable of caring for themselves. As you will see from this report, the Office of the Inspector General provides a critical function by providing accountability regarding access to quality care for these citizens and their families.

Sincerely,

Anita Everett, M.D.
Inspector General

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EXECUTIVE SUMMARY

This report has been created in order to fulfill the requirement as specified by VA 37.1-256.1that each six months the IG report on: recommendations for corrective actions made by the office during the reporting period, identification as to unresolved recommendations, as well as activities of the office. This report contains these three elements and is divided into three corresponding chapters. The reporting period covered within this report is from October 1, 2002 to March 31, 2003.

Chapter One includes the recent activities of the office. This has been a busy and transitional time for the office. Regarding internal functioning, the IG completed ten new unannounced inspections including several secondary inspections as well as full snapshot inspections. The system for monitoring Critical Incidents has continued to emerge. This six-month period, 100% of the reported 684 patient injury events were monitored and reviewed by OIG staff, with 217 events being followed up at a higher level of scrutiny. A report on facility monthly monitoring data has been created. This report provides raw data on trends within facilities that might indicate a need for further clarification or onsite attention. Areas that are monitored through this monthly report include census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. A number of further inquiries and several inspections were performed related to information trends that represented potential concern in response to this system.

Chapter Two contains the actual inspection reports from snapshot inspections that were completed within this reporting period. Within each of these reports is the response to the OIG recommendation that was provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).

Additionally over this time period, there were several secondary reports that were conducted. Secondary reports are conducted in response to a potential serious concern at a facility. Due to the presence of patient confidential information as well as sensitive material designed to promote thorough peer review these reports are not appropriate for public dissemination. Freedom to critically review a clinical course of events is critical in the process for designing better systems of care within a facility and throughout the state facility system. It is critical for the OIG to be able to provide input regarding the quality and thoroughness of peer reviews as conducted by each facility.

Chapter Three contains unresolved findings. Follow-up reviews of 58 outstanding unresolved recommendations were conducted at the seven facilities where snapshot inspections were completed. This included findings from a total of 20 reports.

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CHAPTER 1 - STATE OF THE OFFICE

The Office of Inspector General was created to provide ongoing accountability to consumers and elected officials regarding conditions within the 15 state operated facilities that provide services for persons with mental illness and mental retardation in Virginia. This office was created at a time during which five of the fifteen state operated facilities designed for those with mental disability, were found to have substandard treatment and safety conditions. As of 2003, all but one of these cases has been settled by the facility having met the terms of a negotiated Quality Improvement Plan for each of the involved facilities. Given fiscal strains currently faced by Virginia it is critical that a strong sense of the needs of some of most vulnerable citizens, i.e. those who reside within these facilities.

The vision of the office is that each consumer in Virginia with a mental disability has opportunities to access quality care that promotes recovery such that persons are able to live safe and productive lives in the community of their choice.

In order to fulfill this vision the office established the following mission:

The mission of the Office of inspector General is to challenge the mental health, mental retardation and substance abuse public funded system, to provide quality services for Virginians that are consistent with contemporary clinical guidelines and contemporary financial management strategies.

At the state level the last six months have been associated with great financial budget shortfalls. Under the direction of Governor Warner, there has been close attention to the efficient functioning of virtually every aspect of state government. During this timeframe, the operating budget of the OIG has been reduced by 20%. With this budget, there will be sufficient funding to maintain the current permanent staffing level as well as the statewide travel necessary to fulfill the duties as set forth in VA Code: 37.1-256. These duties include the unannounced inspection of each state facility once a year. For each of these facilities, there must be reporting on: *general conditions, staffing patterns and access to active and contemporary treatment*. Other duties include monitoring the quality of care within the facilities as well as the review of regulations and policies as relates to the care for persons with mental disabilities.

While this has resulted in significant consolidation of planning efforts, at this time we fully anticipate being able to fulfill requirements as set for the in the Code.

CHAPTER 2 – ACTIVITIES OF THE OFFICE

A. INSPECTIONS

The OIG is required to conduct at least one unannounced annual inspection at each of the fifteen state Mental Health and Mental Retardation facilities operated by DMHMRSAS. Unannounced visits are conducted at a variety of times including weekends, on holidays and across shifts.

During this semi-annual reporting period, the office conducted ten inspections.

Seven snapshot inspections were conducted within this six-month reporting period. A snapshot inspection is an unannounced inspection conducted to observe a facility as it normally functions, without advance notice. Snapshot inspections traditionally review basic general conditions of the facility, staffing and activity of patients are directly observed. Additional elements are often added to the core snapshot inspection. In this particular six-month period, access to specialized behavioral management consultation within facilities was evaluated. A snapshot inspection was conducted at each of the following facilities:

Catawba Hospital in Catawba;
Commonwealth Center for Children and Adolescents in Staunton;
Eastern State Hospital in Williamsburg;
Northern Virginia Training Center in Fairfax;
Piedmont Geriatric Hospital in Burkeville;
Southern Virginia Mental Health Institute in Danville;
Western State Hospital in Staunton

Three secondary inspections were conducted. A secondary inspection is conducted in response to a specific concern or complaint received by the office. Secondary inspections often involve patient specific and confidential information. As a result, these reports are generally not released to the OIG website. Secondary inspections were completed at the following facilities in this six-month reporting period:

Central State Hospital in Petersburg;
(2) Western State Hospital in Staunton

B. REPORTS

Reports are the mechanism for communicating the findings and recommendations, which resulted from an inspection. A Plan of Correction (POC) is made for each recommendation made within an OIG inspection report. Implementation of the plan of correction is monitored until successful resolution has occurred.

A change in the definition of the content of a completed report package occurred through an agreement between the OIG and DMHMRSAS in this six-month reporting period. Currently, once the POC has been finalized, DMHMRSAS responses to OIG recommendations are merged into the original OIG report. This merged document, along with the OIG acceptance of the POC are then forwarded as a complete report package to the Governor's Office.

During this semi-annual reporting period there were 15 completed report packages.

These included:

Northern Virginia Mental Health Institute / Report #63-02
Hiram Davis Medical Center/ Report # 65-02
Central State Hospital/ Report # 66-02
Southside Virginia Training Center / Report #67-02
Southwestern Virginia Training Center/ Report # 68-02
Southwestern Virginia Mental Health Institute/ Report #69-02
Western State Hospital / Report #70-02
Commonwealth Center / Report #71-02
Western State Hospital / Report #72-02
Western State Hospital / Report #73-02
Northern Virginia Training Center / Report #74-03
Piedmont Geriatric Center / Report # 75-03
Central State Hospital/ Report # 76-03
Western State Hospital / Report #77-03
Catawba Hospital/ Report #78-03

Governor Warner's Office has been very timely in responding to reports as submitted and has granted release to the OIG website of every OIG report other than those which contain specific identifying consumer information or are peer review documents.

C. SPECIAL PROJECTS

Special projects are activities beyond the regular inspection reporting process. These reports and projects generally are designed to look at aspects of quality of care that are more systemic than at one particular facility. They are designed to improve overall knowledge of the publicly funded system.

The OIG finalized four special project reports, which were initiated during the last semi-annual reporting period. These included:

Community Services Board (CSB)/Family Education and Illness Management Project
Available at www.oig.state.va.us

Mortality Review (October 2000-September 2001)

Preliminary Review of Private and State –Operated Psychiatric Bed Utilization for Children and Adolescents in Virginia
Available at www.oig.state.va.us

Training Center Staffing Interim Update Report
Available at www.oig.state.va.us

The OIG participates in several ongoing committee projects. Engagement in these activities results in increased knowledge of the system and allow for interaction of the OIG with state level stakeholders. There are currently several major ongoing activities that are participated in as follows:

The Inspector General hosted the American Association of Community Psychiatrists (AACP) annual Winter 2003 meeting. In February of 2003, the AACP held its annual Winter Meeting in Virginia. The purpose of this meeting was to provide an opportunity to bring national speakers to Virginia to promote quality and innovation in the public mental health system in Virginia. The Keynote Speaker was Charlie Curie, Director of the federal Substance Abuse and Mental Health Service Administration who is mounting a national campaign on recovery such that all persons with mental disabilities have opportunities to have a life in the community of their choice. Additionally, Dr. Michael Hogan, chairman of the Presidential New Freedom Commission on Mental Health presented a summary of the activities of this presidential commission. Other nationally known speakers addressed recovery in chronic mental illness, statewide implementation of evidence-based services, treatment adherence. Several programs from Virginia were encouraged to present information. These included PACT team outcomes in Virginia as well as a review of the treatment mall concept as developed in Virginia facilities. There were over forty speakers brought to Virginia for this event. The meeting was well attended and received good remarks in the subsequent evaluation.

Psychiatrists in Underserved Areas – The goal of this program is to encourage psychiatrists to pursue practice in a rural or underserved area in Virginia. This program is administered through joint participation of the Virginia Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Inspector General. The program provides support through loan repayment and interaction with medical school training programs to encourage psychiatrists in training to pursue careers in underserved areas in Virginia. Several psychiatrists have been placed in practice in rural areas in Virginia as result of this program.

Olmstead Accountability Committee - Governor Warner requested that a plan to monitor the implementation of the Supreme Court decision regarding Olmstead be developed in Virginia. In response to this, Secretary Jane Woods, together with the Virginia Office for Protection and Advocacy, as well as other agencies and organizations have developed a two year process which will result in an Olmsted Plan for Virginia. The Olmstead decision asserts that under the Americans with Disabilities Act (ADA), the unnecessary institutionalization of persons with mental disabilities constitutes discrimination under certain conditions. Dr. Everett is a member of the task force and has been an active participant in the accountability monitoring work group.

SJR99 Committee preparing a report on Effective Treatment modalities for Children and Adolescents – Dr. Everett was invited to participate with the Youth Commission in the development of a document that presents evidence based and best practices for children with emotional disturbance. Dr. Everett has participated on the steering committee as well as the clinical sub-committee of this process. This process has resulted in a document or resource for clinicians, educators, and families that is designed to provide information regarding effective treatments for particular conditions. This document is reported to have been the most requested document produced by legislative services in the past legislative session.

CSA Project – Previously the IG was invited to participate in a legislative study of the Comprehensive Services Act and served as the chair of the committee on monitoring and

evaluation. Activity in this particular six-month period has been primarily a consultation role regarding clinical elements of a state level data system, which will provide information to enhance capacity to evaluate the efficacy of the CSA program.

Inspector General Study: In the summer of 2002 a legislative study was conducted of the office. This study brought together a number of advocates and other stakeholders and was led by the Honorable Secretary of Health and Human Resources, Jane Woods. The report from this study was completed in late fall 2002. There was strong support for the continuance of the office, however in association with this study, the budget of the Office will be moved into DMHMRSAS in July 2003. The office will continue with the current reporting to the Governor as well as to the Commissioner of DMHMRSAS and The Secretary of Health and Human Resources.

D. DATA MONITORING

Critical Incident Reports

Critical incidents as defined by Virginia Code *§ 2.1-817* are sent to the OIG for review and monitoring. These incidents are those incidents occurring in one of the facilities that are serious enough to be associated with the resident or patient being evaluated by medical staff.

Approximately 684 critical incident (CI's) reports were reviewed within this semi-annual period. The OIG conducted an additional level of scrutiny and follow up for 217 of the 684 reviewed CI's. The information gathered from the additional inquiries was used to identify potential clinical problems with treatment of individuals within state facilities and to track trends in facilities. The information is integrated into the inspections and schedule of the OIG.

Quantitative Data

In order to refine the inspection process so that core risks as identified by DOJ could be monitored, a monthly facility report was instituted in January 2002. This report provides raw data on trends within facilities that might indicate a need for further clarification and onsite attention. Areas that are monitored through this monthly report include census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. The office has used this data to process clarification requests during this six-month reporting period. The requests asked for clarification regarding significant data fluctuations over a period of time. The responses provided by the facilities were satisfactory to meet the needs of the office.

E. FOLLOW-UP REPORTING

All active or non-resolved findings from previous Inspection reports are reviewed through a follow-up process until they have been successfully resolved. In general, evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include interviews with staff, patients, review of procedures, memoranda, medical records, meeting minutes, or other administrative and/or clinical documents.

Through an agreement with DMHMRSAS within this reporting period, the OIG streamlined the follow-up process by eliminating separate follow-up inspections and the previous requirement of a six-month progress report update which was prepared by staff at DMHMRSAS. Presently, follow-up reviews of all active findings are completed at the time of the on-site snapshot inspection. This allows for more timely feedback to the facilities regarding progress towards satisfying agreed upon plans of correction. This change consolidates travel and resources. DMHMRSAS currently provides comments in response to previous active recommendations simultaneously with the plan of correction regarding the snapshot inspection.

Follow-up reviews were conducted at the seven facilities where snapshot inspections were completed. This included findings from a total of 20 reports and 58 findings, which had previously been active or unresolved during prior follow-up reviews.

F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period a formal review has been completed of 13 DMHMRSAS Departmental Instructions and 1 Regulation.

DI1001 – Guideline for Implantation of HIPPA
DI 1002 – Minimum Necessary Use, Disclosure and requests regarding individually identifiable health information
DI1003 – Confidentiality and security measures for protection of information
DI1004 – Notice of privacy practices, authorization, verbal agreements and permitted uses of information for treatment, payment and healthcare operations
DI1005 – Rights of Individuals receiving services relating to information use or disclosure
DI1006 – Complaints processed and rights of Individuals receiving services with regard to protected information
DI1007 – Workforce information and HIPPA Complaints process and sanctions
DI1008 – Business associate contracts
DI1009 – Permitted use and disclosure of individually identifiable health information to external legally authorized officials
DI514 – Outside Employment and acceptance of gift
DI520 – Administrative Leave for victims of natural or technological disasters
DI 521 - Return to Work/Worker's Compensation Management Program
DI 701 – Organization and Maintenance of the Clinical Record

12 VAC 35-105-10 Regulations for licensing Providers of Mental Health Services

G. PRESENTATIONS AND CONFERENCES

During this reporting period presentations were provided for the following state and national groups and meetings associated with the mental health, mental retardation and substance abuse community:

American Association of Community Psychiatrists Annual Winter Meeting
Virginia Alliance for the Mentally Ill annual conference-Overview of OIG
American Psychiatric Association-Physician Ethics in Public Mental Health Funding

Joint Commission on Behavioral Healthcare-Presentation of the OIG Report on access to Children Acute Care Beds in Virginia
Medical Examiners Conference-Overview of Deaths within State Operated Facilities
Keynote Speaker for the Parents and Friends of SEVTC Quarterly meeting
Keynote speaker for the Northern Virginia Mental Health Consumers Association
Keynote speaker at the Northern VA NAMI monthly meeting
Primary Care Association-Recruitment of Psychiatrists for underserved Areas
Chesterfield County CSB

H. MEETINGS

The OIG regularly participates in a variety of forums that address issues relevant to DMHMRSAS facilities and mental health issues.

DMHMRSAS Facility Directors' Meeting;
DMHMRSAS Facility Medical Directors' Meeting;
Virginia Association of Community Psychiatrists;
American Psychiatric Association Scientific meeting
American Psychiatric Association Assembly
Psychiatric Society of Virginia
Regular meetings with Virginia Office of Protection and Advocacy

CHAPTER 3

INSPECTION REPORTS COMPLETED

This chapter contains the actual inspection reports that were completed within this six-month reporting period. Each of the snapshot reports in included in its entirety as well as the response as submitted by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Responses or Plans of Correction are reviewed by OIG prior to being accepted. Additionally there were several peer review reports that were conducted within this time frame, These reports are not available in their entirety because they often contain patient sensitive information as well as material that is intended for sensitive peer review deliberation.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
FALLS CHURCH, VIRGINIA
LYNN DELACY, ACTING DIRECTOR

OIG Report #63-02

An unannounced Snapshot Inspection was conducted at the Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Virginia on July 16 -17, 2002. The purpose of a snapshot inspection is to conduct an unannounced inspection of a facility with a primary focus on three quality of care areas. During this type of inspection, the team reviews (based on observations, interviews and the review of supporting documentation) the following: the general conditions of the facility, including cleanliness and comfort; whether there are adequate numbers of staff; and the availability of activities designed to promote recovery.

Overall, the facility was noted to be clean and comfortable. Efforts to make this setting appear less institutional were evident. Staffing patterns were noted to be adequate to provide an appropriate level of supervision and staff-patient interaction.

The facility administration currently offers services designed for both the medical and active psychosocial rehabilitation treatment needs for the chronically mentally ill adult population. There was a concern noted regarding the numbers of patients observed not actively participating in the programs offered.

The facility provides support and training for staff educational advancement.

Finding 1.1: Overall, the facility was generally clean, comfortable and well maintained.

Recommendation: Continue to maintain the facility and maximize efficient use of limited space.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the Inspector General's recognition of NVMHI's efforts. NVMHI continues to maintain the treatment environment with both preventive and corrective housekeeping and engineering programs. Regular rounds are conducted to monitor the environment, and work orders are promptly submitted for any required repairs.

Finding 2.1: Staffing patterns for nursing services were adequate.

Recommendation: Continue to provide adequate staffing patterns.

DMHMRSAS Response: DMHMRSAS concurs. Adequate staffing patterns will continue to be provided.

Finding 2.2: Seven of eight staff members interviewed did not understand the reporting structure for abuse and neglect.

Recommendation: Retrain all staff regarding the correct reporting process and procedures as outlined in this policy. Review current mechanism within the facility through which allegations are reported to assure that all allegations are properly handled and addressed.

DMHMRSAS Response: DMHMRSAS concurs. New Employee Orientation and Annual Update Training currently include a Human Rights video explaining the Reporting and Investigation of Abuse, Neglect and Exploitation. Effective immediately, the Training Coordinator will assess via verbal interaction, individual understanding of the procedure involved in the different processes as part of the training program. The training Department also will provide a presentation based on the facility policy, *Reporting and Investigating Abuse and Neglect of Patients*, as a hospital wide in-service to staff. This presentation will be available for staff meetings and as an on-line training module. In addition, nursing leadership will regularly test staff competencies on the reporting process through interviews and role-playing a variety of scenarios. Nursing Unit Managers will re-test staff knowledge in three (3) months via verbal reviews and role play situations on each nursing units.

The Nursing Managers will discuss the abuse and neglect reporting structure within the nursing unit and department-wide meetings in order to better understand the sources of confusion and/or barriers. Using the information gained, strategies will be developed to assure compliance with the direct reporting requirement. These strategies will encompass ways to provide direct report as well as to notify the supervisor that coverage must provided for the employee leaving the unit as well as allow supervisor opportunity to take immediate action to protect the patient.

Finding 2.3: NVMHI offers a variety of supports to staff seeking to pursue advanced training.

Recommendation: Continue to provide a variety of supports for staff to advance. Make sure that supports and training opportunities are made known to staff.

DMHMRSAS Response: DMHMRSAS concurs. Scheduling adjustments to support staff participation in training will continue to be provided. Financial support will be consistent with facility budget and guidance from Central Office.

Finding 3.1: NVMHI continues to monitor and revise the active treatment program in response to patient functioning, experience and individual treatment goals.

Recommendation: Continue to offer active treatment that is designed to meet individualized needs. Review methods for incorporating the model of active treatment noted on the mall on the admissions unit.

DMHMRSAS Response: DMHMRSAS concurs. All discipline directors will discuss barriers to increased individual and group activities to support newly admitted patients to achieve treatment goals. Based on findings, the PSR Director and the Director of Psychiatry will provide leadership for unit based program development. The Clinical Leadership Group will discuss paradigms for recovery based programs on all units.

Since the treatment mall integrates individuals into groups that are related to their specific treatment needs, the number of F unit patients attending treatment mall programming varies from hour to hour depending on the patients' needs and the groups being offered that hour.

Therapeutic activities are scheduled on F unit throughout each afternoon. Some of these activities include: aftercare meetings with the community liaison, psychotherapy groups, leisure education groups, substance abuse groups, and music therapy. In addition, the Performance Improvement Team (see Response 3.2) is exploring more efficient ways of capturing other elements of active treatment provided in addition to groups.

Nonetheless, the clinical leadership acknowledges the unique challenge of providing active treatment and engaging patients on an admissions unit where the average length of stay is 14 days. The need to develop a different programming model is under consideration. This issue will added to the charter of the Performance Improvement Team as noted in Response 3.2.

Finding 3.2: Tracking of active treatment participation was identified as inconsistent.

Recommendation: The OIG supports the convening of the performance improvement team to review current status of the active treatment program, including patient participation, strategies for actively engaging persons in their recovery process and effective, consistent documentation of participation both individually and collectively. NVMHI is encouraged to dialogue with Central State Hospital and Southwestern Virginia Mental Health Institute on strategies engaged by the facilities in these areas.

DMHMRSAS Response: DMHMRSAS concurs. A Performance Improvement Team focused on patient attendance at programming began work in June 2002. One sub-group is working specifically on putting mechanisms into place that will ensure consistent tracking of all active treatment, including off-site programming (such as attendance at community PSR programs) and evening and weekend activities. A second sub-group of the Performance Improvement Team is working on identifying strategies that treatment teams can utilize to encourage more active participation by patients in their treatment. Additionally, the PSR Director has been in direct contact over the last month with the PSR Directors at CSH, ESH and WSH to investigate successful strategies utilized at those facilities. After review of those strategies by the NVMHI Performance Improvement Team, one or more of these strategies will be pilot-tested with the goal of determining the most effective strategy(ies) appropriate to the facility's population.

Finding 4.1: Record reviews reflected that the overall treatment provided patients, including the treatment and discharge planning process, was individualized; linking the initial assessments, treatment planning and discharge needs to identified barriers.

Recommendation: Continue to document the clinical process of linking assessments to treatment and discharge.

DMHMRSAS Response: DMHMRSAS concurs. NVMHI will continue to monitor the documentation of the clinical process linking assessments to treatment and discharge to ensure that gains are maintained in this area.

HIRAM DAVIS MEDICAL CENTER
PETERSBURG, VIRGINIA
DAVID ROSENQUIST, DIRECTOR

OIG Report #65-02

A Snapshot Inspection was conducted at Hiram W. Davis Medical Center in Petersburg, Virginia during July 29, 2002. The purpose of a snapshot inspection is to conduct a brief unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

Many improvements have occurred at this facility since the OIG first reviewed the facility in 1999. Major renovations have been completed. During this inspection, the facility was noted to be clean, comfortable and well maintained.

There has been a significant increase in nursing staff coverage, which has diminished the use of mandatory overtime. This has continued since the last inspection as confirmed by nursing staff interviews. The facility offers support for staff members seeking career advancement.

Since the integration of rehabilitation services, the facility has made an increased effort at providing active interventions for these complex and medically fragile patients. Continued efforts at getting appropriate intervention to maintain and in some cases increase the individuals' level of functioning is needed.

Finding 1.1: The facility was clean, comfortable and well maintained.

Recommendation: Continue with planned efforts to provide increased opportunities for stimuli to be available for all patients at the facility.

DMHMRSAS Response: One plan to increase opportunities for stimui, the Patient Pavilion has been completed and will be inaugurated with a Patient-Family Picnic September 25, 2002. The pavilion will increase opportunities for patients to be outside in a covered shelter. A workgroup has met twice to develop plans for using the pavilion.

To increase opportunities for increased stimuli inside the facility, the staff office space in the 3rd floor Therapeutic Recreation Room is being consolidated to increase patient use of the room. Nursing takes patients to this room when it is not in use by Recreation. This increases patient socialization and allows the patients increased time out of their rooms. To increase patient interaction and to normalize mealtimes, part of the room is being used for patient dining. This eliminates the need for patients eating in the hallway as they had previously done due to space limitations.

Other efforts to increase patient activities and mobilization include:

- Two volunteers who focus on reading to patients and assisting with patient transport to activities.
- A music group run by the Social Services Department supplements regularly scheduled Recreation groups.
- Rehabilitative Services and Nursing Service work cooperatively to find the most appropriate wheelchairs or other mobility aids for getting patients out of bed.
- Rehabilitative Services contacts the home facility of any new admission to have any custom wheelchairs transferred to HWDMC for the patient's continued use.
- Rehabilitative Services is works cooperatively with the SVTC Wheelchair Evaluation Team and Wheelchair Shop to ensure that patients have the most appropriate mobility aid.

Finding 2.1: Staffing patterns were consistent with facility staffing expectation despite only one RN providing coverage for both units on the 3rd Floor.

Recommendation: Review current practice of staffing RNs to assure that adequate coverage is maintained for these complicated patients.

DMHMRSAS Response: Four Registered Nurses have been employed since this survey was conducted. All are currently in the process of completing clinical orientation. These additional Registered Nurses will assist in alleviating the issue of one RN covering for both 3rd floor units. One RN may be used to provide coverage for both units on the 3rd floor in the following situations:

1. The patient acuity level is low.
2. There are enough Licensed Practical Nurses on duty (minimum of 8-9 LPN's) to support the Registered Nurse.
3. The RN assignment frees her to circulate and make frequent rounds.
4. The Nursing Supervisor on duty (on-call) gives approval, and makes the determination that one RN will not jeopardize the patients.

OIG Clarification Request to DMHMRSAS Response: Provide additional information regarding utilization of an acuity-based system for nursing staffing.

DMHMRSAS Response to OIG Clarification request: HWDMC Nursing department uses hours per patient day (HPPD) formula as a guideline for staffing rather than an acuity-based system. For a census of 70 to 74 patients, the minimum HPPD is 5.4. Clinical activities, however, are closely evaluated when making staffing decisions. Examples of clinical activities that are taken into staffing considerations are:

1. More than two intravenous medications via IV therapy or via heplock.
2. Patient admission that requires close supervision and assessment such as post-operative patients, and pneumonia.
3. Unstable medical condition.
4. Use of restraints.
5. Anticipated complex admission to coming from other DMHMRSAS facility.
6. More than 2 critical patients such as unstable respiratory conditions, chest pain, cardiac condition, abdominal distention, and persistent vomiting.

Finding 2.2: Use of mandatory overtime has been very limited during the past six months.

Recommendation: Continue to discourage the use of mandatory overtime as a remedy for staffing shortages.

DMHMRSAS Response: The facility will continue to monitor, and analyze the mandatory overtime data collected monthly; continue to hire Float Pool staff (P-14), as supplemental staffing; use patient acuity as the baseline for staffing decisions rather than using the mandatory overtime to meet the numbers; continue to enforce the Nursing staffing adjustment policy, wherein employee time schedules are posted for a six -week period with requests for planned absences after posting is granted only if the employee requesting off switches days off with another staff member. This maintains appropriate numbers of staff to accommodate any unplanned absences, thereby reducing mandatory overtime use.

Finding 2.3: HWDMC coordinates internally and with surrounding facilities to offer a variety of supports to staff seeking to pursue advanced training.

Recommendation: Continue to fund and facilitate opportunities for staff to receive advanced career training.

DMHMRSAS Response: HWDMC encourages employees to attend school for upward mobility. Funding for school is based on the criteria set forth in the HWDMC Employee Educational Assistance Instructions. Currently, thirteen nursing staff are pursuing advanced nursing careers. Two Licensed Practical Nurse are enrolled in Registered Nurse Programs, ten Certified Nurse Aides are enrolled in Licensed Practical Nurse programs, and one RN is enrolled in a Bachelor of Science in Nursing program. Four other non-nursing staff are pursuing advanced careers in fields such as computer science, business management, healthcare and social work. In addition, one of the nursing staff successfully completed the transitional LPN to RN program in 2000, utilizing the Educational Leave and the educational assistance provided by HWDMC. The work schedules of the employees who are enrolled in advanced career classes are accommodated based on their class schedule, which results in an approved special shift schedule. The employees enrolled in school are also exempted from the mandatory overtime during their class days. Although these special work schedule accommodations are provided to these employees, appropriate coverage for patient care is still the main priority.

The Petersburg campus (HWDMC, SVTC and CSH) has been pursuing Workforce Development initiatives. SVTC is leading these initiatives that include the School –at – Work Program, and community college classes on campus. Governor Warner has officially designated the DMHMRSAS Petersburg Campus as the "Workforce Development" demonstration and pilot site. Classes will include RN, LPN, or any other college courses including computer technology, HVAC, and childcare. Twenty-nine employees took the John Tyler Community College admissions test last August 2002. There are plans to apply for several Grant programs for funding. A meeting was held on September 20th with a representative of the Capital Compassion Fund.

Finding 2.4 HWDMC has experienced a change in psychiatric consultant**.**

Recommendation: Continue to support access to psychiatrist for those patients in need at HWDMC.

DMHMRSAS Response: Until recently, psychiatric consultations for those patients permanently assigned to HWDMC are provided by locum tenens physicians who had experience managing patients similar to our patient population. Contract psychiatrists from the Virginia Commonwealth University, Medical College of Virginia Section (MCV) are now used. There are many advantages to further developing relationships with MCV. Instead of one locum tenens physician, there are several board certified psychiatrists involved with patients in an academic setting and full time coverage is available if questions arise when the contract psychiatrist is not physically present at HWDMC. The academic setting also provides current and developing medical knowledge.

Patients transferred from Central State Hospital to HWDMC on special hospitalization status for medical problems, continue to be followed by their attending psychiatrists.

Finding 3.1: Active treatment is challenging for this complex and medically fragile population.

Recommendation: Continue efforts at assuring that each person has the opportunity to engage in appropriate levels of activity in order to maintain and/or improve their current level of functioning.

DMHMRSAS Response: The Restorative Team continues to guide planning and implementing patient restorative programs. Policies and procedures for a Bowel and Bladder program and Splinting and Positioning program have been developed including staff training and Team review. Future programs include Range of Motion and Dining.

The Therapeutic Recreation Department has started using a new Die-Cut machine with patients. This machine enables patients to create many paper craft projects.

With more patients getting out of bed in specialized wheelchairs, more patients are able to go on rides or travel to outings in the facility's wheelchair lift van.

Social Services, Therapeutic Recreation, and Occupational Therapy are exploring ways to implement an Assistive Technology Program for patients. HWDMC patients may be transported to the SVTC Technology Lab when not in use by SVTC patients.

CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA
LARRY LATHAM, DIRECTOR

OIG Report #66-02

A Snapshot Inspection was conducted at Central State Hospital in Petersburg, Virginia during July 30, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

During this inspection, the facility was noted to be clean, comfortable and well maintained. Members of the inspection team had difficulty determining the procedure for accessing Buildings 93 and 94 during the second shift as neither building provides for instructions regarding entry. After several attempts to enter Building 93, a team member followed a group of patients into the

building that were returning from an outing without anyone questioning the purpose for the visit or the team member's identity.

Staffing patterns were consistent with facility expectations for coverage during the second shift. Staff interviews indicated that overtime had been steadily increasing during the past several months. This was attributed to vacation requests, staff shortages and call-ins. Interviews revealed that the facility offers support for staff members seeking career advancement of which several expressed interest in participating in the courses that are to be conjointly offered on campus through a cooperative effort between SVTC and the local community college.

Record reviews revealed maturity in the psychosocial rehabilitation programs and the documentation of active treatment goals. The goals were clearly linked to assessments and focused on individualized barriers to discharge.

The Local Human Rights Committee had not been able to maintain a quorum in order to approve policy and procedure changes which resulted from the human rights regulations promulgated in November 2001. This delay prohibits this body from successfully executing it responsibilities and needs to be addressed by the Office of Human Rights.

Finding 1.1: Overall, the buildings toured were clean, comfortable and well maintained.

Recommendation: Preserve the current focus on maintaining a clean, odor free and comfortable environment that enhances treatment.

DMHMRSAS Response: DMHMRSAS concurs, and is gratified at the OIG's recognition of the positive advances made in the ward environments at CSH. Monitoring of all patient care area environments, both from a housekeeping and an aesthetic standpoint, will be ongoing.

Finding 1.2: Buildings 93 and 94 did not provide adequate instruction for visitors regarding entry into the buildings.

Recommendation: Post instructions outside of the door regarding procedures for entry into the building. Train staff regarding security expectations.

DMHMRSAS Response: DMHMRSAS concurs. A CSH Task Force currently is re-evaluating all aspects of visitation, to include: policy formulation, family notification regarding visitation times and contraband issues, space accommodations, access to the buildings and signage. The issues of access and signage will be given priority and work on these will begin immediately. The CSH Director of Nursing will initiate a needs assessment no later than October 4, 2002. Upon completion of the assessment, an operational plan will be developed to ensure appropriate access. Signage and any necessary plant modification (i.e., wiring) will be identified and ordered no later than November 15, 2002.

A memorandum will be sent to all facility staff to remind them of the security issues related to failure of diligence in checking identification of persons entering the buildings.

Finding 2.1: Staffing patterns were adequate and consistent with the facility's expectations.

Recommendation: Maintain staffing patterns that meet facility expectations while monitoring the use of mandatory overtime to prevent staff "burn-out" and decreased morale.

DMHMRSAS Response: DMHMRSAS concurs. CSH will maintain adequate staffing levels according to hospital guidelines. Overtime will continue to be monitored, analyzed and decreased whenever possible. The amount of overtime used is driven by a number of factors, such as the number of vacancies, the number of staff out on vacation or sick leave, the number of patients scheduled for medical appointments outside of CSH, and the number of patients requiring one-to-one coverage for safety or medical reasons. More in-depth analysis is being done to differentiate between mandatory and voluntary overtime.

A former Administrator-on-Duty (AOD) RN, who due to medical problems is unable to resume former duties, has been reassigned to oversee scheduling for the entire campus and to manage all overtime use. A procedure is going to be piloted that will require documentation and monitoring of justification for overtime, with Nursing Administration sign-off. The Ward Managers and RNCs will be re-trained to assure their competency in the use of KRONOS to determine on a daily basis when schedules need to be adjusted to avoid overtime.

Finding 2.2: Interviewed staff indicated that the use of mandatory overtime has increased over the last three months, particularly on the 2nd shift.

Recommendation: Explore the option of cross training staff facility-wide to increase the pool available for overtime shifts.

DMHMRSAS Response: There appears to be an inconsistency between the information given to the OIG interviewers and CSH data regarding overtime. The CSH KRONOS data for 3 months prior to the OIG visit demonstrates that, of the nursing staff working in Buildings 93 and 94 that evening, no staff members had completed at least two overtime shifts a week during that period as claimed. The majority of overtime shifts were voluntary rather than mandatory. Of the three staff working mandatory overtime in building 93 that evening, one had averaged 2 hours overtime per pay period in the 6 pay periods from May 10 through August 9, 2002. The second averaged 6 hours and the third 9 hours per pay period. It is unclear what the staff meant by the information that they conveyed to the interviewers.

All CSH civil patient nursing staff are cross trained across all civil patient wards. Forensic staff are cross trained across all civil patient wards in addition to forensic wards. (Civil staff are not cross trained to work in forensics due to the need to be extremely familiar with the additional security measures and due to class and compensation issues.) Although attempts are made to minimize the pulling of staff from one ward to the other, it occurs regularly in order to maximize staffing levels, provide necessary coverage and minimize the use of overtime CSH will continue to cross train staff across all civil wards and will continue to make assignments in a way that maximizes the numbers and expertise of existing staff.

Finding 2.3: The facility provides opportunities for staff to pursue career development.

Recommendation: Expand the current focus of staff training to improving staff knowledge about the benefit of training to career development.

DMHMRSAS Response: All CSH employees are given information about tuition

reimbursement for career development. Information about all LPN and RN schools in the area is disseminated and the Training Department has added a federal funding application to the information.

The SVTC Workforce Development Director will continue to provide direction to the Southside campus on workforce development. She is working with the local community college to facilitate staff participation in educational opportunities. In August 2002, the college entrance exam was provided to staff. Unfortunately, only one person of the 29 on campus who took it, passed.

The *School at Work (SAW)* program is being held on campus for 2 semesters. The Department of Labor *SAW* program is specifically designed to assist staff to obtain post-high school education. CSH currently has 6 participants in the first semester. Four additional staff signed up for *SAW,* but were unable to pass the qualifying test (Test of Adult Basic Education) which is written at a ninth grade level. Because of the high failure rate on the entrance exam, CSH is considering implementation of an 8-module remedial alternative called *Workplace Essential Skills.*

Experience at CSH has shown that career development related to DSA-level staff has involved MUCH remedial assistance, since many who are interested cannot pass qualifying tests. Therefore, CSH will continue to offer the current transition classes. Many of these staff want to expand their career prospects and are fully aware of the benefits of doing so, but are dealing with personal challenges (such as single parenthood, lack of funds, etc). A portion of them also need to first upgrade their skills before even beginning the career development opportunities.

The CSH Training Department will continue to encourage staff participation in the various staff development activities. CSH will also continue to work to provide new and innovative opportunities for training, knowledge and education that are realistic, convenient and affordable.

Finding 3.1: Record reviews revealed an integration between initial assessments, treatment planning and involvement in active treatment programming.

Recommendation: The documentation of treatment goals has significantly improved. Expand upon past successes through the development of realistic individualized treatment goals that continue to be based upon on-going clinical assessments.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the recognition of the improvements made to the documentation of treatment goals. The CSH Clinical Leaders of regularly conduct qualitative record audits and provide feedback to the treatment team members. The next phase of review will focus on realistic, individualized treatment goals based on current clinical assessment. The Clinical Leaders will continue to provide feedback to the treatment teams.

Finding 3.2: The facility has developed a mechanism for increasing patient involvement in active treatment programming.

Recommendation: The OIG commends the staff for identifying and addressing this problem. It is recommended that this information be shared with other facilities that have Treatment malls or psychosocial rehabilitation programs.

DMHMRSAS Response: DMHMRSAS concurs, and is pleased by the recognition given to this example of inter-disciplinary problem-solving related to patients' involvement in programming. On October 1, 2002, the CSH Director of Rehabilitation Services attended a statewide meeting of Rehabilitation Directors from the other state hospitals; and shared the facility's successful methods of increasing patient participation and making programs more meaningful to them.

Finding 4.1: The approval of policies and procedures reflecting changes in the human rights regulations has been delayed.

Recommendation: Address the issue of delayed decision-making by LHRC by developing alternatives for completing committee functions in the absence of a quorum.

DMHMRSAS Response: The implementation of the schedule for the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* was articulated in Commissioner Kellogg's memo of October 18, 2001. The schedule indicated that as of July 1, 2002, in order to provider to be in compliance with regulations, they must have their policies and procedures approved by the Human Rights Advocate. It was also required that the policies and procedures were to be submitted to the Local Human Rights Committee (LHRC) for review. The implementation schedule does not include a requirement for LHRC approval of the policies and procedures by July 1, 2002 or any other date.

Central State Hospital and the Human Rights Advocate have been working actively on the facility's policies and procedures since April 19, 2002. The policies and procedures have been reviewed and revised four times since then. To date, however, the Human Rights Advocate has not yet approved CSH's new policies and procedures. Once they are approved, the policies and procedures will be submitted to the LHRC for review.

Central State Hospital has submitted plans for the completion of the staff human rights training to the Office of Facility Operation/ Quality Assurance. These plans are not dependent on the actions of the Human Rights Advocate or the LHRC.

The revised Human Rights regulations require that a Local Human Rights Committee (LHRC) meet at least four times per year. The bylaws of each LHRC can increase the frequency of its meetings. The LHRC at CSH is one of the few that meets monthly; and this schedule was set to ensure more timely review of complaints. This LHRC unexpectedly lost several of its members in early summer 2002. The Committee cancelled its meeting in July and did not have a quorum at the August meeting. The State Human Rights Committee appointed five new members to this committee on September 6, 2002, and the CSH LHRC conducted a meeting with a quorum on September 13, 2002.

The successful functioning of the LHRC is a shared responsibility amount the providers, the Office of Human Rights and the state Human Rights Committee. The Office of Human Rights and the SHRC monitors the activities of each LHRC regularly. The State committee has the authority to reassign responsibilities to other committees and has done so when necessary.

SOUTHSIDE VIRGINIA TRAINING CENTER
PETERSBURG, VIRGINIA
JOHN HOLLAND, DIRECTOR

OIG Report # 67-02

A Secondary Inspection was conducted at Southside Virginia Training Center in 2002 in response to a serious incident. In accordance with Virginia Code §2.2-3705(A)(6), this report is not available for public release.

SOUTHWESTERN VIRGINIA TRAINING CENTER
HILLSVILLE, VIRGINIA
DALE WOODS, DIRECTOR

OIG Report # 68-02

The Office of Inspector General conducted an unannounced Snapshot Inspection at the Southwestern Virginia Training Center (SWVTC) in Hillsville, Virginia on September 11, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. During this type of inspection, the team reviews the following: the general conditions of the facility, including cleanliness and comfort; whether there are adequate numbers of staff; and the availability of activities designed to assist patients in their recovery/skills building. The team for this inspection was comprised of two members of the OIG and a consultant.

Overall, the facility was noted to be clean, comfortable and well maintained. It is recommended that the facility review the use of weight bearing shower curtain bars in four of the cottages as was noted during the inspection.

Despite a recent increase in mandatory overtime, this facility continues to address this issue. The number of overtime hours remains lower than during previous reviews at this facility, although 8 of 12 staff interview expressed concerns that this may change due to proposed statewide budget cuts. The facility has realized how the strategic placement of personnel in key positions within this facility enhances services and maximizes resources with the recent hiring of the family nurse practitioner. Psychiatric coverage and a PhD psychologist continue to be staffing issues that needs to be addressed.

The facility continues to provide an array of active treatment and habilitative opportunities for the residents.

Finding 1.1: Overall, the facility is clean, comfortable and well maintained.

Recommendation: Continue to maintain this environment in the manner that reflects value in providing a safe and comfortable environment for these residents. Actively address the lack of privacy in Cottage 5C.

DMHMRSAS Response: Environmental and safety rounds will remain in place to ensure that the facility remains a clean, safe and comfortable environment for the residents.

Several approaches have been attempted to correct the 5C issue. The facility is now looking at a material that will allow a person to look out the window but blocks view from the outside into the room.

The resident in this room has had a particular dislike of window treatments, to which he responds by taking it down. A behavioral plan to address that behavior is being carried out as part of the individual's program plan.

Finding 1.2: Bars in the showers in the cottages toured present a potential risk to the residents.

Recommendation: Review of the use of this type of bar be conducted by the safety committee and risk management.

DMHMRSAS Response: The Safety Committee and the Risk Manager will review the appropriateness of the current shower rods, explore alternatives and make recommendations to the SWVTC Executive Director. This task is targeted for completion by December 16, 2002.

Finding 2.1: Staffing patterns were noted to be consistent with facility expectations.

Recommendation: Maintain staffing patterns that meet facility expectations for patient safety and therapeutic involvement. Continue to monitor use of overtime and staff morale.

DMHMRSAS Response: Staffing levels and overtime will continue to be monitored on a daily basis. Staffing levels will be maintained at levels that ensure a safe and therapeutic environment.

Finding 2.2: Staff interviewed had a good working knowledge of the contents and application of the new Abuse and Neglect policy.

Recommendation: None. This sampling of staff indicates a good understanding of this essential policy.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

Finding 2.3: The recently hired nurse practitioner has implemented several preventative initiatives within the facility.

Recommendation: None. It will be important for this facility to be able to maintain this key position.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

Finding 2.4: The number of on-site hours of service provided by the psychiatrist per month has decreased.

Recommendation: Central Office review the possibility of utilizing psychiatric staff from SWVMHI or other sources as a part of their job function to provide coverage at this facility until permanent solutions are available.

DMHMRSAS Response: The Medical Director, Office of Health and Quality Care, and Central Office management have been monitoring the psychiatric needs of all Training Centers on an on-going basis. SWVMHI is willing to "share" psychiatric staff whenever its resources allow, but that has not been possible recently. Various options are being explored. Discussions are underway about shifting psychiatric resources from the mental health facilities to the Training Centers as psychiatric services are moved to the community as part of system re-investment initiative. Availability of other psychiatrists on a part-time basis also is being explored.

SWVTC regularly keeps Central Office informed of changes in psychiatric coverage. SWVTC will continue efforts to increase the number of on-site psychiatric hours of service, with the goal of providing at least 16 hours of on-site service per month.

Finding 2.5: SWVTC would benefit from the addition of a PhD level psychologist.

Recommendation: Review options for securing this position in order to enhance treatment services.

DMMRSAS Response: Such a position is a priority for staffing enhancement at SWVTC. Efforts will continue to fund such a position. One option being explored is transfer of psychologist(s) to SWVTC from a psychiatric facility as part of the current system re-structuring initiative.

Finding 3.1: SWVTC offers a wide array of active treatment activities.

Recommendation: None. Continue to maintain and develop these services.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
MARION, VIRGINIA
CYNTHIA McCLURE, DIRECTOR

OIG Report # 69-02

A Snapshot Inspection was conducted at the Southwestern Virginia Mental Health Institute (SWVMHI) during September 12, 2002. The primary purpose of this inspection was to review the facility in three quality of care areas: the general conditions of the facility, staffing patterns and active treatment provided.

Several sources of information were utilized in the completion of this report including a tour of the facility, observations of interactions between the staff and patients, interviews with

administrative and clinical staff and patients, and a review of documentation including client records, performance initiatives, and general programming.

The facility was well maintained and comfortable. Patients reported feeling safe, comfortable with the living conditions and engaged in the treatment process. Staffing patterns were consistent with the facility expectations. Staff reported a minimal amount of overtime during August 2002.

SWVMHI continues to conduct a performance improvement initiative designed to address issues associated with the recruitment and retention of nursing staff.

The facility has been expanding its psychosocial rehabilitation programming. Training by the Boston Center continues to be offered as a way of enhancing staff skills in the recovery model. It is the goal of the facility to generalize the principles of the recovery model to unit management. The primary area of concern during this inspection centered on the absences of documented crisis plans as a safety net for patients re-entering the community at discharge.

Finding 1.1: Tours of the facility demonstrated that the environment was clean, comfortable and well maintained.

Recommendation: Continue to focus on the provision of providing a safe and comfortable therapeutic environment.

DMHMRSAS Response: Southwestern Virginia Mental Health Institute will continue to focus on providing a safe, secure environment for the clients. The Security Enhancement System, fully implemented last year, continues to provide enhanced patient safety. Security staff makes regular rounds on all shifts with emphasis placed on patient care and treatment areas. Security staff spend additional time in patient areas where acuity is the highest. Ensuring patient safety and comfort are maintained are areas of major focus at SWVMHI.

Finding 2.1: Staffing patterns were noted to be consistent with facility expectations.

Recommendation: Maintain staffing patterns that meet facility expectations for patient safety and therapeutic involvement.

DMHMRSAS Response: This year, all staffing patterns for each unit at SWVMHI were reviewed and revised to establish adequate levels of appropriate nursing staff on a consistent basis across the week. This has assisted in more efficient use of nursing staff resources as well as enabling the Staffing Nurse Coordinators to deploy available staff to areas of highest acuity. A task force of direct care staff and nurse managers was formed two months ago and has met three times thus far to assist scheduling practices. **Several goals of this group are:**

- To promote staff ability to "self schedule" within certain parameters
- Maintain the needed staffing patterns.
- Consider weekend duty incentives as budgetary demands allow.

A standing Nursing Staffing committee continues to meet monthly membership includes:

- Facility Director
- Human Resources Manager
- Nursing/Human Resource employees.

Finding 2.2: SWVMHI celebrated Nurses Appreciation Week through a variety of creative activities and events.

Recommendation: Continue to find ways of recognizing and supporting the nursing staff**.**

DMHMRSAS Response: DMHMRSAS encourages the celebration of Nurses Week. At SWVMHI, employee work profiles for nurse managers are being revised to include an element related to positive recognition of staff that will be evaluated annually. An employee pole determined the following recognitions to be meaningful:

- "Employee of the month" plaques
- Letters published in the newsletter
- Food recognition events
- Opportunities in meetings to acknowledge achievements

Quarterly Nursing Forums continue to be held, and staff input is acknowledged as appropriate.

Finding 3.1: SWVMHI continually reviews and implements programs that will enhance the principle of the recovery model throughout the facility.

Recommendation: Continue efforts to broaden the principles of recovery within this facility.

DMHMRSAS Response: The Rehabilitation Department at SWVMHI continues to enhance and monitor the Psychiatric Rehabilitation (recovery enhancing) programs through an ongoing Quality Management program. Indicators this year continue to track Quality of Programs, Effectiveness of Programs and Patient/Staff Satisfaction with programs.

Employees are supported in becoming competent in the application of skills and technologies of rehabilitation service delivery through training and technical assistance. Specific Quality Management Indicators are as follows:

- Indicator #1 - Ensures, through supervision and coaching, that supervisors regularly observe and document the quality of practitioner's skills during the service delivery session.
- Indicator #2 - Documentation reviews to ensure standards of Treatment Planning, progress note documentation and that patient is progressing toward established objectives within designated time frames.
- Indicator #3 - gives patients and staff a survey tool by which they can express opinions specific to Rehabilitation programming.

Additionally, the Rehabilitation Department of SWVMHI continues to work closely with each Unit Director and Treatment Team in reviewing the menu of services, changing the components to meet patient needs. Recent additions to the provision of services include:

- Individualized programming for the geriatric population
- Short-term fast tracked skill program for patients in the Admissions Unit
- Recovery readiness program for patients in the Admissions Unit
- Afternoon enrichment sessions for Extended stay patients
- Weekly LEAP (Leadership, Empowerment, and Advocacy Program) Consumers from the local Clubhouses assist SWVMHI patients gain skills and knowledge that will support re-entry to desired communities.

FINDING 4.1: Record reviews revealed that "safety net "crisis plans were not consistently developed for patients at the time of discharge.

Recommendation: Develop and document crisis intervention plans as a routine part of the clinical discharge process.

DMHMRSAS Response: Discharge planning, including crisis planning is under the joint purview of the facility and the Community Service Board responsible for the client, SWVMHI has educated and reminded facility and CSB staff regarding the importance of including a crisis plan for all clients being discharged. The CSB After Hours Crisis number, is designated as the routine crisis plan by the Discharge Protocols for Community Services Boards and Mental Health Facilities and is included in all cases. Pursuant to Section 5.2 of the DMHMRSAS Discharge Protocols, "when specialized crisis plans are recommended, Facility Staff shall notify the CSB that a specialized crisis plan needs to be developed as part of the final discharge plan". The facility will notify all CSBs in the region of this finding on the part of the OIG seeking to ensure responsiveness to the need for a crisis plan.

WESTERN STATE HOSPITAL
JACK BARBER
STAUNTON, VIRGINIA

OIG Report #70-02

A Secondary Inspection was conducted at Western State Hospital in 2002 in response to a serious incident. The Inspection relied, in part, upon information provided by committees at Western State Hospital that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspection included a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, this report is not available for public release in order to protect the privacy of the patients referenced in this report concerning this incident and the privilege for peer review documents.

COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS
JOE TUELL
STAUNTON, VIRGINIA

OIG Report # 71-02

A Snapshot Inspection was conducted at Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia on November 19-20, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

CCCA is the only state facility solely dedicated to the evaluation and treatment of persons under the age of eighteen. CCCA also serves the Commonwealth by conducting inpatient 10-day court ordered evaluations of children. The facility has a capacity of 48 beds.

Overall, the facility was noted to be safe, clean and provides a comfortable environment. There are four units, two designed for children's programming and two for adolescents. All units are co-ed, though a nursing station separates the rooms that are occupied by one gender from the other. Patients do co-mingle in common areas but are prohibited from entering opposite sex bedroom or bathroom areas. Bedroom areas were generally messy and unkempt. Staff explained that patients are encouraged to maintain their bedrooms but this is limited due to human rights concerns.

Staffing patterns were appropriate on the evening of this inspection. There were adequate numbers of staff present to safely and appropriately supervise these patients. CCCA operates 48 beds; the total census during the inspection was 35. Recreational therapist were present on each units providing structured activities. A majority of patients were involved in these activities. For those who were not involved, it was generally due to clinical instability.

Behavioral principles are integrated in the unit management system. Unit psychologists have completed additional training in Cognitive-Behavioral Therapy and utilized this technique, which has been identified as effective with certain short-term treatment clients.

Finding 1.1: Overall, staffing patterns were consistent with facility expectations.

Recommendation: None. This facility has had the good fortune to be able to attract many individuals with at least a Bachelor's Degree in the position of direct care assistants. It is often difficult for facilities to be able to maintain staff with this level of education within these positions because of the nature of the work and the associated compensation. The Commonwealth Center provides staff with opportunities to increase both their experience and knowledge base, which enables them to enhance their skills.

DMHMRSAS Response: DMHMRSAS appreciates the OIG's recognition of CCCA 's effort to attract the best-qualified individuals available for all staff vacancies.

Finding 2.1: CCCA provides opportunities for the patients to maintain their educational status as well as participate in active treatment

Recommendation: None. This facility has completed a number of refinements to the provision of active treatment. Most notable has been the introduction of more formalized and structured psycho-educational substance use and abuse programming. As noted during the follow-up reviews conducted during this inspection, this service has become an integral part of active treatment programming. CCCA has been able to hire an additional staff member to conduct groups. Active programming remains primarily unit-based, which is different than active treatment provision at the other facilities, but this is a function primarily of the population served by the facility.

DMHMRSAS Response: CCCA will continue to develop active treatment based on needs of clients including the provision of education regarding substance abuse for clients who have been assessed to be in need of this education.

Finding 3.1: Overall, the facility was clean, comfortable and well maintained. Efforts at making this setting appear more home-like were noted.

Recommendation: Review staff's understand that patients are not required to maintain their bedrooms in an orderly fashion due to human rights issues. This was addressed during a previous OIG inspection and follow-up. It was indicated in the plan of correction that the facility would clarify expectations that all patients would be held accountable for maintaining their bedrooms as part of the unit expectations.

DMHMRSAS Response: CCCA will establish unit expectation that individual patients have responsibility for maintaining their bedroom areas in a responsible manner based on their physical and mental abilities to do so.

Finding 4.1: Behavioral Programming at CCCA is primarily integrated within the unit management system.

Recommendation: None.

WESTERN STATE HOSPITAL
JACK BARBER
STAUNTON, VIRGINIA

OIG Report # 72-02

A Snapshot Inspection was conducted at Western State Hospital (WSH) in Staunton, Virginia on December 3-4, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and access to Active Treatment.

Overall, the facility was clean and well maintained. Team members observed that 7 out of 12 bathrooms inspected had toilets that were not flushed. These recently renovated bathrooms have an automatic flushing toilet system. Hygiene products cluttered surfaces in shower areas. Upon a follow-up check several days later (December 12, 2002), the same toilet conditions remained. A seclusion room on one of the units had a clump of dried feces as well as smear marks noted on the wall. The on-duty nurse could not identify the last time the room was used for seclusion. This area had been cleaned prior the re-inspection observations.

Staffing patterns were appropriate on the evening of the inspection and consistent with facility expectations. There were adequate numbers of staff present to safely and appropriately supervise these patients.

Western State Hospital offers active treatment programming in a number of psychosocial rehabilitation treatment mall programs. Patients are assigned for participation in one of these

programs depending upon their level of functioning and stability. A wide variety of programming is offered both during the day and early evening hours.

This facility makes use of a number of behavioral programming strategies on the unit management level as well as in the formation of individualized assessments and treatment planning. Formal behavioral therapy plans are developed when the treatment team determines it is clinically indicated. This could be due to behaviors that are identified as dangerous to the patient and others, result in repeated PRN usage, or incidents of seclusion and restraint usage. Thresholds are established and referrals are made if thresholds are exceeded. Team psychologists have the option of referring a patient for consultation at any time. The facility also has a specialized behavioral management consult team, which provides behavioral consultation services throughout the hospital.

Behavioral Management is monitored and implemented on the unit through the team, by involvement of specialized consultants and through the behavioral management committee. Each of these components provides a specialized function in the development and oversight of behavior management within the facility. WSH has developed a method of integrating each of these elements so that a patient focus is maintained.

Finding 1.1: There were adequate numbers of staff present to safely and appropriately supervise the patients during the evening shift tour.

Recommendation: None. Staffing patterns were consistent with facility expectation during the evening shift when unit tours were conducted.

DMHMRSAS Response: DMHMRSAS appreciates recognition of WSH's accomplishment in staffing evening shift appropriately.

Finding 2.1: Western State Hospital provides an array of active treatment options for patients in a variety of treatment mall settings, depending on each patient's level of functioning and stability.

Recommendation: None. This facility has an established process for reviewing and updating active treatment programming that is based on consumer needs.

DMHMRSAS Response: DMHMRSAS appreciates recognition of WSH's review process for updating active treatment programming.

Finding 3.1: Unsanitary conditions were noted in 7 out of the 12 bathrooms inspected as well as one seclusion room.

Recommendation: Have members of Buildings and Grounds conduct inspections of the bathroom to determine whether the equipment for the automatic flushing of toilets is functioning properly. Timely cleaning of the seclusion rooms following use needs to occur.

DMHMRSAS Response: A number of actions have been, or will be, taken to improve the cited sanitation conditions. WSH Physical Plant Services will complete a thorough review of all automatic flushing toilets by March 1, 2003. All ordinary problems will be addressed as part of

this review. Should there be major operational problems that require unit replacement resulting in high cost, WSH Executive Staff will discuss these and develop an action plan by April 1, 2003.

In addition, the findings of the Inspector General have been shared with unit staff. Nursing Staff has already sent a reminder to all unit staff regarding ongoing maintenance of cleanliness for the seclusion rooms. Housekeeping staff will check each seclusion room at the beginning of their workday and will correct any sanitation problem found. This expectation has been communicated to housekeeping staff.

Finding 4.1: Western State Hospital utilizes behavioral programming both on the unit management level and in the formation of individualized behavioral therapy plans, as clinically indicated.

Recommendation: Review opportunities for expanding, as appropriate, the expertise of this team into community setting as an additional tool for assisting patients make a successful transition into community-based services.

DMHMRSAS Response: DMHMRSAS appreciates recognition of the fine work done by the Behavioral Consultation Team (BCT) at WSH. The BCT will modify its current referral form to explicitly include the opportunity for consultation related to transitional/ discharge planning. The BCT will respond to consultation requests from CSB psychologists or other appropriate staff within resource capacity. Our Community Services Director will make CSBs aware of this resource. Community staff will be allowed to attend training in behavioral knowledge/competence conducted at WSH.

WESTERN STATE HOSPITAL
JACK BARBER
STAUNTON, VIRGINIA

OIG Report #73-02

A Secondary Inspection was conducted at Western State Hospital in 2003 in response to a serious incident. The Inspection included a review of precipitating factors and a clinical review of the management of the incident. Although the patient's name is not within the report, release of this report in its entirety may be able to be linked to the patient due to publicity associated with this case. Several recommendations regarding performance improvement were made within this report and will be followed up per the standard operating procedures of the OIG which includes follow up of 100% of recommendations until they have been successfully executed.

NORTHERN VIRGINIA TRAINING CENTER
MARK DIORIO
FAIRFAX, VIRGINA

OIG Report # 74-03

A Snapshot Inspection was conducted at Northern Virginia Training Center in Fairfax, Virginia on January 30-31, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients.

NVTC is one of five training centers dedicated to providing residential and active treatment services to persons with mental retardation. This approximately 200-bed facility primarily serves individuals from the Northern Virginia area.

Overall, the facility was clean comfortable and well maintained. NVTC has engaged in several projects designed to make this institutional environment appear more home-like. Recently the facility completed a Victorian Garden Project and continues with plans to contract with one of the local universities in establishing an internship in design as an additional way of developing creative ideas for environmental improvements.

NVTC maintains a staff to client ratio that provides for the training, care and safety needs of the residents it serves. Residents at NVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning.

The use of Behavior Management was reviewed as a part of this inspection. This was found to be a well-developed and mature part of the treatment component at NVTC.

UNIT OR BUILDING**:** Members of the inspection team conducted tours of all four units within the facility.

Finding 1.1: NVTC maintains a staff to client ratio that provides for the training, care and safety needs of the residents it serves.

Recommendation: NONE.

DMHMRSAS Response: NVTC will continue to maintain a staff to client ratio that provides for the training, care and safety needs of the residents served.

Finding 2.1: Residents at NVTC are provided with opportunities to participate in active treatment programming in a variety of settings depending upon their level of functioning.

Recommendation: None.

DMHMRSAS Response: NVTC staff will continue to provide a variety of opportunities to participate in active treatment programming in a variety of settings. NVTC will continue to use available resources to promote programming appropriate to an individual's level of functioning

and preference.

Finding 3.1: Overall, the facility was clean, comfortable and well maintained. There was evidence that the facility had worked to make this institutional setting appear more home-like.

Recommendation: None.

DMHMRSAS Response: NVTC will continue to encourage each residential unit to develop a home-like appearance.

Finding 4.1: NVTC has a well- developed and mature behavioral management program.

Recommendation: Consideration should be given by Central Office to developing a formalized mechanism through which residents at other Training Centers could benefit from this valuable resource, which is concentrated at NVTC compared to other training centers in Virginia.

DMHMRSAS Response:

The Department Appreciates the OIG's recognition of the outstanding work being done at NYTC. DMHMRSAS has also recognized the value of the behavior management program as it is practiced at NVTC. Each training center has its unique populations and needs as well as unique staffing patterns that influence how behavior management programs can and are implemented. The NVTC program was sent to all training centers in written form for their consideration. Over 200 employees were given the opportunity to attend training for certification in behavioral analysis and there was a cooperative effort with George Mason University for further education. DMHMRSAS continues to pursue ways to share the seeds of excellence at all facilities.

PIEDMONT GERIATRIC HOSPITAL
BURKEVILLE, VIRGINIA
WILL PIERCE, DIRECTOR

OIG Report # 75-03

A Snapshot Inspection was conducted at Piedmont Geriatric Hospital in Burkeville, Virginia on February 4-5, 2003. The OIG also conducted a follow-up visit to the facility on March 3, 2003 to review the new program, which was not in place during the time of the snapshot inspection. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas which are consistent with basic rights as established under the federal Civil Rights of Institutionalized Persons Act. The areas are as follows: safe environment as manifested through the general conditions of the facility and staffing patterns, and, the active clinical treatment provided for patients.

Piedmont is the only state facility solely dedicated to the evaluation and treatment of persons over the age of sixty-five. The facility continues to recruit nursing positions in order to provide adequate nursing coverage for these medically complex and behaviorally challenging patients. One of the ongoing problems at this facility has been access to RN level staff on evening and

weekend shifts. In negotiations with the DOJ for other facilities in Virginia, one RN for each shift on each unit was a minimal requirement. In order to facilitate this as well as current budget reductions, five units were reconfigured into four. Supervisory positions have been assigned to unit nursing duties in order to enhance direct care contact.

Programs had been suspended during the initial visit to the facility but team members were informed and observed active treatment programming during the follow-up visit. The newly implemented SMILE (Skills Mastery, Individual Living Enhancement) program is offered to patients residing on 1 West. Limited unit based programming is available for patients on the other units depending upon their level of functioning. On the day of the visit, programming on 3 West was not occurring due to staff shortages, according to staff interviewed. It was anticipated that therapeutic programming would commence within 2 weeks.

Tours on all the units revealed the facility to be overall clean, comfortable and well maintained.

Finding 1.1: **Progress has been made toward the goal of one RN per unit per shift.**

Recommendation: Pursue the plans for a minimum of one RN per unit per shift. The OIG requests updates regarding the progress in addressing this staffing issue.

DMHMRSAS Response:

The following are being implemented to increase RN coverage on the evening and night shifts:

Rotation of all RNs who have previously worked predominately day shift to night shift effective Feb./March schedule. (2W and Ground Floor to start rotation when RN positions are filled and 2 positions were filled 3/10/03)

Assigned shift supervisors (3) to night shift on 3W, Gr. Fl. and to the evening shift on 2W who will be providing direct care. (These shift supervisors provide relief coverage for the Night and Evening Coordinators.)

Assigned RNs from 2E (Consolidated Unit):

1 Unit Coordinator to Gr. Floor (provides direct care)
2 to Ground (rotating)
1 to 2 West (rotating)
2 to 1 West (1 West has the Admission Suite and JCAHO mandates 24hour RN coverage)

RN recruiting is done continuously

1 new hire 3/10/03 for Gr. Floor
1 new hire 3/10/03 for 2 West
Awaiting acceptance to offer to applicant for night shift –2 West
Advertising for evening and night shift RNs

Recruitment and retention of RN's continues to be a facility priority as the shortage of RN's continues to grow nationally.

Finding 2.1: PGH has implemented a new program for patients on 1 West. Limited therapeutic programming was available for the patients on the other three units.

Recommendation: PGH needs to assure that programming is provided for all patients depending upon their level of functioning. Scheduled actives were reportedly not occurring due to staffing shortages. This needs to be reviewed.

DMHMRSAS Response:

For clarification purposes, it needs to be noted; the hospital has reviewed its Psychosocial Rehab staffing which is as follows:

3W – RT & MT (2 FTE)
2W – RT & MT (2.5 FTE)
1W – SMILE program
2 RT & 1 MT (2.0 FTE)
GF – AT & MT (1.5 FTE)
2 OT's going to all units (.5 FTE per unit)
Contracted Physical Therapy

On March 3, 2003 one of the RT's was absent and there was no coverage for his groups. We are reviewing coverage and how to provide coverage for activities in the event of staff absences.

In addition to the above staffing, each unit has group treatment programs provided by Nursing, Social Work and Psychology. During the past 60 days the Director of Rehabilitative Services has been working closely with the Nursing Department by having Rehabilitation Staff work cooperatively with the Clinical Nurse Specialists and Unit Coordinators on the other Units to plan and continue to schedule appropriate treatment
Modalities, activities, and events for the patients. The Senior Recreation Center has been added to the Program Schedule for each Unit. The Occupational Therapist (2) will also plan and conduct psychosocial groups (Sensory Stimulation, ADL Training and Horticulture) in addition to assisting the CNS's with Feeding Programs. The Clinical Leadership Team does quarterly review of Active Treatment hours and adjustments are made to meet any deficits. (A copy of the report on active treatment hours is available for the date of the follow-up visit on March 3, which confirms the OIG observations.)

Individual Treatment Plans are developed by Multi-disciplinary Treatment Teams and implemented with consideration of the patients' level of physical and cognitive functioning.

NOTE: As indicated above, PGH has recently implemented a new Senior Recreation Center where patients can get off the unit and attend various programs. The Center modalities are available one day a week to patients from all units. In addition, forensic patients (housed on 3-West) attend every day. The program is designed to allow patients the freedom of choice in recreational, diversional / music and special events**.** The Center provides the opportunity for patients to interact with others outside of their present environment, similar to centers in the community. A Sensory Stimulation Room is being developed with sensory lights and a large aquarium, which should be completed by the end of March. There will be four rooms set-up with activities scheduled and carried out in each of the rooms daily, based on patient's level of functioning. Pet Therapy, Gardening, and outside Entertainment Groups will be forthcoming.

Unit based Program staff also have the opportunity to plan or request their own special activities or events for their patients on their scheduled days at the Center.

April 21, 2003 is our projected date to have completed the modification of our psychosocial treatment programs throughout the facility. We continually evaluate the effects of these programs on the outcome on their treatment goals.

Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

Recommendation: None.

DMHMRSAS Response: The Department appreciates the OIG findings related to the environment of care at this facility.

Finding 4.1: PGH is currently reviewing and revising policies regarding behavioral treatment.

Recommendation: The OIG requests that this policy be forwarded for review upon its completion.

DMHMRSAS Response:
The draft of Behavior Treatment Policy (Hospital Instruction #47) is in final review with the Clinical Leadership Team. (Draft copy attached.) An Implementation date of April 1, 2003 has been set. The facility and the Department would welcome the comments of the OIG regarding this policy.

CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA
LARRY LATHAM, DIRECTOR

OIG Report # 76-03

A Secondary Inspection was conducted at Central State Hospital in 2003 in response to a serious incident. The Inspection included a review of precipitating factors and a clinical review of the management of the incident. Although the patient's name is not within the report, release of this report in its entirety may be able to be linked to the patient. Several recommendations regarding performance improvement were made within this report and will be followed up per the standard operating procedures of the OIG which includes follow up of 100% of recommendations until they have been successfully executed.

WESTERN STATE HOSPITAL
JACK BARBER
STAUNTON, VIRGINIA

OIG Report #77-03

A Secondary Inspection was conducted at Western State Hospital in 2003 in response to a serious incident. The Inspection included a review of precipitating factors and a clinical review of the management of the incident. Although the patient's name is not within the report, release

of this report in its entirety may be able to be linked to the patient. Several recommendations regarding performance improvement were made within this report and will be followed up per the standard operating procedures of the OIG which includes follow up of 100% of recommendations until they have been successfully executed.

CATAWBA HOSPITAL
CATAWBA, VIRGINIA
JACK WOODS, DIRECTOR

OIG Report - #78-03

A Snapshot Inspection was conducted at Catawba Hospital (CAT) in Catawba, Virginia on January 22 and February 25, 2003. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three basic areas. The areas are as follows: the general conditions of the facility, staffing patterns and activity of patients. A review of the application of the principles of behavioral management was also conducted.

A tour was completed on all four of the units within the facility. There is an admissions unit, a short term adult unit, a long term care unit for young adults and the geriatric unit. Overall, the facility was noted to be a safe, clean and comfortable environment. The facility has made efforts to make this very institutional setting more home-like. Recently a large screen television was donated for each of the units.

Staffing patterns were appropriate during the time of this inspection. There were adequate numbers of staff present to safely and appropriately supervise these patients. CAT operates 110 beds; the total census during the inspection was 101.

Finding 1.1: Catawba maintains a staffing pattern that is consistent with the facility expectations. Staffing patterns allows for the safe supervision and treatment of the patients. The compassion and dedication of this staff support therapeutic environment.

Recommendation: None.

DMHMRSAS Response: The Department appreciates the OIG's recognition of this very professional staff.

Finding 2.1: Catawba provides a variety of active treatment programs for the patients based on their stability and level of functioning.

Recommendation: None

Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

Recommendation: None.

Finding 4.1:Catawba has developed a mechanism for empowering the teams in implementing behavioral strategies through the regular use of the Behavioral Management Committee.

Recommendation: None.

Chapter 4

Active Findings and Recommendations

This chapter contains findings and recommendations made by the OIG that had not been resolved as of March 31, 2003.

CATAWBA HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION
JULY 10, 2000
OIG REPORT # 26-00

Finding 2.3: Record review did not reflect the treatment as verbally described by the staff interviewed.

Recommendation: Revisit with staff the process of documenting so that the chart reflects current treatment.

DMHMRSAS Response: Concur. The Facility Clinical Director and Chief of Staff have begun training all treatment teams in the importance of documenting in patient charts appropriately, accurately and in a timely fashion. Treatment plans are reviewed according to policy (i.e., every 7 days, every 14 days, and every 30 days as indicated) for priority needs and include a discussion of resolved issues. Discrepancies will be resolved as teams review diagnoses, treatment plans and discharge plans at each meeting. This will ensure the record reflects the most current plan of treatment.

In addition, the treatment planning policy for documentation relative to the treatment plans (Catawba Hospital Policy and Procedure 20.01) has been distributed. The Chief of Staff has directed the head of each treatment teams to act upon the policy and training, immediately.

The head of each treatment team will review the records monthly to ensure that the treatment plans and all documentation is accurate and consistent with the client's needs and treatment decisions.

6 Month Status Report: 7/1/01
COMPLETED 08/00 There were no recommendations regarding treatment plans at the time of the 2000 JCAHO and Medicare surveys. A Treatment Plan Workgroup is working on the development of an automated treatment planning system. Once implemented, this should improve the accuracy and quality. Treatment Plans more accurately reflect the provision of treatment. Training of staff in the new system will include documentation requirements. Refer to June, 1999 report # 3.3 Documentation training is provided to clinical staff during new employee orientation.

Monthly chart reviews are performed on a sample of records to ensure compliance with documentation requirements.

OIG Comment - *During the June 2001 visit, record reviews demonstrated some improvements in the treatment plans. A performance improvement team has been working on this process and expects to implement a new, automated system within the next quarter. This finding remains* ***ACTIVE.***

6 Month Status Report: 01/01/02

During the past six months, Catawba Hospital staff have been involved with, and provided leadership for, specific areas of the DMHMRSAS system-wide project on the development or acquisition of a computer based treatment-planning program, which would be utilized throughout the facilities, and ultimately would be part of an automated medical record. This is an ongoing workgroup, which is continuing to review and evaluate existing treatment planning systems.

Catawba Hospital's Treatment Plan Workgroup has concurrently continued working on the development and operationalization of a computer-based treatment planning program that would address all of the requirements of the Departmental Instruction on Treatment and Habilitation Planning while incorporating the practical information and applications often generated by the Treatment Teams. During the next six months, Catawba Hospital plans to finish development of this software and begin testing prior to potential full implementation.

OIG Comment- *Interviews and record reviews revealed that this facility continues in its efforts to revise the treatment plans. As noted, the automated process is not completed at this time. This finding remains ACTIVE.*

6 Month Status Report: 07/01/02

Catawba Hospital staff continues to be involved in the DMHMRSAS project involving the development or adaptation of a computer-based treatment planning system as an ultimate part of an automated medical record. This part of the project is ongoing at this time.

The software has been developed for Catawba Hospital's computer-based automated treatment plan. At this time, the workgroup is in the process of finishing the content of this plan which involves the definition of problem areas and associated objectives and interventions. We have been recently working toward improving Treatment Plans for high-risk events, including aggression and falls. The content involving aggression has been added to our existing computer-based treatment planning program. The content involving falls should be added to the program within the next six weeks. Both of these will also be utilized in the new treatment plan structure. We plan on piloting and refining and, if successful, utilizing the new treatment planning program within the next six months.

OIG Comment *– Interviews with administrative staff revealed that the facility continues with its plan for implementing a computer-based automated treatment plan. At the time of the March 2003 inspection, the process had not been completed. Overall, the treatment plans in the records reviewed identified problems with addressed presenting symptoms that were barriers to discharge. Goals were clearly written and tasks outlined.*

Catawba reports continued participation in the DMHMRSAS project of developing and implementing a state-wide automated medical record. As this project has not been completed, this finding remains ***ACTIVE.***

March Updated Report: 03/1/03
Catawba Hospital is currently utilizing an automated treatment planning system and has been working toward improving the quality and individualization of this system. Recently, Performance Improvement Workgroups have developed and implemented new treatment plans for the high-risk areas of aggression and potential for falls. Implementation of an improved treatment-planning problem regarding medication compliance has also been developed. Catawba Hospital continues to work with the DMHMRSAS on the development and implementation of a statewide automated treatment planning system as part of an automated medical record. During the past quarter, staff from Catawba Hospital met with representatives from MCV and Duke University Hospital regarding piloting of the CMRIS automated medical record system at Catawba Hospital. At this time, funding for this pilot program has not been allocated.

CENTRAL STATE HOSPITAL
SECONDARY INSPECTION ON INCIDENT OF MARCH 9, 2000
APRIL 27, 2000
OIG REPORT #20-00

Finding 2.3: There is limited ability for staff at one facility to learn from adverse events at another facility.

Recommendation: The Department of Mental Health, Mental Retardation and Substance Abuse Services should set up a mechanism such as a performance improvement (PI) Team to review this missing opportunity. The system as a whole is currently not benefiting from the experience of individual parts of the system.

DMHMRSAS Response: DMHMRSAS concurs. DMHMRSAS has initiated a number of efforts for facilities to learn from adverse events within facilities. These include: The Office of Health and Quality Care meets with Medical Directors of all facilities to discuss policies/ procedures across facilities which may ensure best practices of care leading to specific enhanced case outcomes; this same Office is scheduling the first Quality Council meeting which will establish a variety of work groups to address system-wide concerns and methods for sharing recommendations; the Office of Risk Management will use root cause analysis on specific events to be shared during quarterly meeting with Facility Risk Managers with specific focus on system-wide risk reduction strategies and; the Office of Facility Operations/Quality Assurance

will share exemplary corrective action plans with other facilities relative to adverse events in an effort for all facilities to learn from the experiences of singular events. The Associate Commissioner for Community and Facility Services will meet with the Associate Commissioner for Administration and Regulatory Compliance and the Central office Risk Manger to discuss the appropriate procedure for distributing results and processes for responding to sentinel events.

6 Month Status Report: 7/1/01

The Division of Health and Quality Care (OHQC), under the leadership of the Central Office Medical Director, meets quarterly with the facility Medical Directors to discuss current clinical issues and to share best practices in order to develop system-wide improvements. Clinical topics addressed at these meetings have included: suicide assessment and documentation; application of practice guidelines; and substance abuse assessment as part of risk assessment process, among others. OHQC, in collaboration with the Central Office Risk Manager,has provided technical assistance and guidance to facilities on appropriate procedures for addressing sentinel events.

OHQC convenes the Quality Council meetings on a quarterly basis, the first being on July 26, 2000.

The Office of Facility Quality Improvement (OFQI, formerly known as the Office of Facility Operations/Quality Assurance) has participated in the Facility Directors meetings on an ongoing basis. OFQI has provided feedback and information on exemplary action plans regarding various clinical and administrative issues identified by the Department of Justice, the OIG, Department for Rights of Virginians with Disabilities, and other regulatory bodies. During 2001, meetings have been held with the Facility Directors of the Training Centers to focus on issues specific to clients who have mental retardation.

In Spring 2001, DMHMRSAS changed its administrative structure by creating a new position, the Assistant Commissioner, Division of Facility Management (DFM). This position has responsibility for the operational management of all the state MH and MR facilities. [The responsibility for CSBs now belongs to the Assistant Director of the Division of Programs.] The new DFM Assistant Commissioner, a psychiatrist with facility management experience, began full-time employ in June 2001.

OIG Comment - *With the recent changes in administrative structure in Central Office additional practices may be implemented. At this point there is not evidence that Sentinel event reviews at one facility are of benefit, in terms of improving quality of care, at all the facilities. This finding is* ***ACTIVE.***

6 Month Status Report: 01/01/02

The Medical Director, Office of Health and Quality Care, will make discussion of clinical issues and improvements resulting from Sentinel Event reviews a standing item on the agenda for the quarterly meetings of the facility Medical Directors. For each discussion of a Sentinel Event, the involved facility Medical Director will briefly address in general terms the problem(s) and clinical dynamics that led to a sentinel review; and he/she will

present recommendations and corrective actions taken as a result of the review and any documented outcomes from those actions. The OHQC Medical Director will lead discussion regarding ways in which other facilities can make similar improvements as pro-active prevention of similar events. The OHQC Medical Director also will set, and will ensure compliance with, the expectation that each facility Medical Director share information on the general issue or problem and corrective actions with their respective facility Executive Director and Management team.

The OHQC Medical Director will advise the Assistant Commissioner, Division of Facility Management (DFM), of the identified issues and corrective actions upon completion of the Sentinel Event review and will make recommendations for system-wide change. The Assistant Commissioner, in collaboration with the OHQC Director, will address identified issues and corrective actions with facility directors, both individually and as a group. The Assistant Commissioner meets with the facility directors at least quarterly. In addition, he holds special group meetings as indicated to ensure timely response to emerging issues.

OIG Comment – *Review of the agendas for the January 25 and May 10th medical directors meetings indicated that the proposed review of critical incidents and other peer review concerns has not yet occurred. This finding is ACTIVE.*

6 Month Status Report: 07/01/02

At the May 10th Medical Directors' meeting, there was discussion about including Sentinel Events Reviews as a regular agenda item for the Medical Directors' meeting. Concern was expressed about information disclosed that was covered by the peer review protection of confidentiality, and the Inspector General's role in relation to such disclosures. The question was raised whether the Inspector General would be bound by the same requirements of confidentiality as the other members of the group.

An alternative was presented that the Inspector General would bring cases to the medical directors' meetings about which she had already obtained knowledge. That would satisfy the intent of the interest in making lessons learned from adverse events at one facility available to other facility medical directors and, by extension, their staffs, without the risk of unprotected disclosure. This issue will be put on the agenda by the Medical Director, Office of Health and Quality Care, for the next Medical Directors' meeting for further clarification.

CENTRAL STATE HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION
JULY 17, 2000
OIG REPORT # 29-00

Finding 3.4: Staff relates that the use of mandatory overtime for Human Service Care Workers (psych tech) had increased recently.

Recommendation: Please forward the current assessment of and plan for the psych tech overtime situation in building 39 at CSH. If there is not a current working plan, please forward the date by which one will be completed.

DMHMRSAS Response: See above plan, "CSH Action Plan for Direct Staffing" (Response to Finding 3.3).

6 Month Status Report: 7/1/01

The FMHT overtime hours during the IG visit in July 2000 were extraordinarily high at approximately 7200 hours for that month. The number of FMHT overtime hours have decreased to the point that during the most recent quarter, the monthly hours have averaged approximately 2600 hours. The Nursing Department developed a specific deployment plan to ensure that consistent coverage across the wards and across the days of the week. In addition, a number of the vacant FMHT positions have been filled.

Overtime continues to be monitored for patterns and trends by job categories (MHT, FMHT, SST). Identified problems will be immediately referred to Nursing for correction/ improvement.

OIG Comment - The administration has been attending to issues related to overtime hours and have developed a system to track and reduce mandatory hours. This finding is ***ACTIVE.***

6 Month Status Report: 01/01/02

We continue to monitor overtime usage on the wards and during the most recent 3 month period, the monthly overtime hours have averaged approximately 2600. This remains substantially below the approximately 7200 hours during the month of July 2000 when the Inspector General visited. The hours of overtime have leveled off , with forensic usage remaining higher than that of the civil wards. In an effort to address the forensic overtime hours, additional P-3 and P-14 FMHTs have been hired. Much of the overtime usage remains tied to one-to-one coverage for special precautions and suicide precautions necessary for patient safety. Nursing Management and the Medical Staff continue to monitor the use of 1:1 staffing for necessity and appropriateness. Efforts to minimize mandatory overtime have been active by using voluntary and P-14 before utilizing mandatory overtime. Mandatory overtime is used only in situations where other efforts to provide coverage have failed. In an effort to ensure safety of our clients, voluntary overtime has been limited to 16 hours per pay period per employee.

OIG Comment *– Interviews indicated that the use of mandatory overtime has declined within the past quarter. The facility has instituted a process to monitor overtime that reflects a direct management priority in which the Assistant Directors of Nursing review the overtime shifts on a daily basis to address and justify the number of overtime hours worked. The facility continues to put effort into the recruitment and retention of DSA and nursing staff. The facility has a recruitment and retention committee, which is exploring the possibility of creating a campus wide daycare program onsite as well as providing educational courses on campus, bringing the classroom to the staff so that opportunities for enhancing knowledge and skills are more readily available. The facility has made great progress on addressing this issue, but because of the new ideas in addressing this issue and the historic tenure of this issue, the OIG will continue to follow the facility's progress. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02

Overtime use continues to be monitored for necessity and appropriateness by Nursing Management and the Medical Staff. The number of hours in December 2001 was extremely high due to all the holiday coverage that had to be provided. While it has come down from that high level, it continues to be somewhat high due to 1:1 coverage for special precautions and suicide precautions deemed necessary for patient safety. There have also been a number of special hospitalizations outside of Hiram W. Davis Medical Center that require round-the-clock coverage. We continue to minimize the use of *mandatory* overtime, using P-14 coverage and voluntary overtime as much as possible.

SVTC's Workforce Development Director is working with the three facilities on the Southside Campus on a dynamic workforce development plan. She worked with a committee on the development of a Workforce Fair. Workforce Development Day was held May 21, 2002. (Please see ATTACHMENT A.) The purpose of the fair included: giving both present employees and members of the community information about careers here; providing time for people from the community to complete job applications; providing information about educational opportunities we hope to provide in the future (GED, workforce training, college classes held on this campus) to assess interest; and, allowing our community partners (community college, VEC) to be here in contact with our employees and people from the community. All the facilities were pleased with the excellent turnout. The outcome information is still being analyzed to determine the next steps in our workforce development.

CENTRAL STATE HOSPITAL
SECONDARY INSPECTION
DECEMBER 17, 2001
OIG REPORT #52-01

Finding 1.3: The majority of patients interviewed did not feel safe on the forensic units.

Conclusion: The facility has implemented a number of safety measures in an effort to promote a safer environment. Given the feedback from the patients, it would be advantageous to utilize their information and concerns in addressing this on-going effort by creating an environment where safety is a known priority for both the staff and patients. A program which openly

involves patients in aggression prevention and management should be considered such as the following program from Atascadero State Hospital in California.

> *Norm of non-violence. Although violence may occur, we challenge the notion that violence is to be expected in a forensic setting. The norm of non-violence pervades all interactions involving patients and staff and between patients. All members of ASH community, patients and staff alike, are personally responsible for the safety and security of the hospital environment.*

Recommendation: Facility management and staff should work with patients to foster an awareness of safety that begins with facility orientation for all new inpatients.

DMHMRSAS Response: In the Department's efforts to create an environment with safety as a known priority, CSH management has recently completed work on an updated mission, values, vision and philosophy statements. Safety and security were underlying principles upon which the statements were based. The values statement clearly articulates non-violence as a priority, stating that "the expectation for each patient shall be that violence is unacceptable and each staff member shall be confident that should violence occur, they are trained and prepared to handle it in the most humane and safe manner." Please see ATTACHMENT A.

The facility continues to monitor aggression and intervenes to prevent aggression whenever possible. A comprehensive aggression management program was implemented in July 2000. Since that time, there has been a statistically significant decrease in the number of forensic patient to patient assaults. In fact it is highly unusual for a forensic patient to assault another patient. Only two such incidents occurred for all patients in Buildings 39 and 96 in both December 2001 and January 2002.

During the admission/orientation to the wards, patient responsibilities are discussed along with patient rights. Patients are told that they are responsible to behave in non-aggressive and non-threatening ways and that violence is not acceptable. A significant part of our programming is instrumental in assisting our patients toward an overall awareness of safety. Patients are taught skills to assist in dealing with their own impulses, as well as dealing interpersonally with others. *Anger Management, Handling Hassles, Coping Skills,* and *Stress Management* are some of the groups that provide education and skills development in this area. These are very common groups due to the large number of patients referred**.**

6 Month Status Report: 07/01/02

CSH Management continues to promote the hospital's mission, values, vision and philosophy with non-violence as a priority. Patients continue to be told that they are responsible to behave in non-aggressive ways and staff continues to assist them in finding non-aggressive ways of interacting and coping.

This message of non-violence is reinforced with the staff through the training and implementation of individual aggression management plans that focus on intervening to prevent aggression. During the period since the OIG visit took place, there have been eight treatment team referrals in Forensics for the development of individualized aggression management plans. The number of incident of patient to patient aggression in Buildings 39 and 96 has averaged less than 3 per month.

In an effort to enhance safety on the most acute wards in Bldg. 39, the provision of rehabilitative services has been redesigned. The most high risk segment of the patients previously served by the acute treatment mall in Bldg. 39 is now receiving rehab services on ward 8 during treatment mall hours. The programming of 39's acute treatment mall has been redesigned so that there are fewer patients in each activity. Both of these changes are intended to provide this very acute population with a more stable and therapeutic treatment environment.

Another measure to enhance the forensic patients' feelings of safety is that SMTs are held over through the night shift whenever assessment of the general level of risk on the acute wards of Bldg. 39 warrants their presence.

Finding 1.4: Interviews with direct care staff indicated that on-going and updated communication is the most effective tool for providing security for both the patients and residents.

Conclusion: There is currently inadequate clinical information exchange between shifts for staff, particularly direction care staff.

Recommendation: Review and make necessary revisions to current procedures for enhanced communication between shifts in forensics units.

DMHMRSAS Response: Effective January 10, 2002, shift times at CSH have been adjusted to allow a full 30-minute overlap of staff at shift change. The previous 15-minute overlap had not allowed oncoming FMHT staff to stay for the entire report secondary to their being required to assume their posts in order to relieve the departing staff. With the new 30-minute overlap, all arriving staff are being required to attend the verbal shift report. Shift report will continue to be recorded for staff being pulled to the ward after the beginning of the shift.

Information regarding a patient being placed on restrictions will continue to be shared face-to-face, included in shift report, documented in the 24-hour report and posted in the nursing station to augment communication.

6 Month Status Report: 07/01/02

The staff communication book, patient information book, verbal and recorded shift reports, increased shift overlap and the posting of patient precautions/restrictions in the nursing station all remain in effect. Special attention is being paid to ensuring that the patient information books are kept up-to-date and contain all specific alerts and management issues for each patient. In addition, when a patient has been identified as having a medical condition, the record is flagged with a medical alert sticker.

The Quality Council chartered a ward-based Performance Improvement project on Bldg. 39-6 focused on effective nursing communication exchange between shifts. It is hoped that the outcome of the project will provide a prototype for use on all the wards.

Finding 1.5: Interpretive services were inconsistently provided for a non-English speaking patient.

Recommendation: Availability of adequate translation services is essential in the provision of culturally competent services. Translators are to provide a reasonable degree of treatment and confidential treatment planning are essential.

DMHMRSAS Response: CSH has entered a contract with "Language Learning Services" to provide interpretative services for more than 10 languages over the phone. Their services are available 24 hours a day, seven days a week, 365 days a year. While there has been limited need, their experience with the contractor has been positive and they will continue to use them. As a reminder, at the February Nurse Management meeting, a memorandum was given to each of the nurse managers by the Director of Nursing with instructions to post the number for the Language Learning Center and to discuss this resource with their respective staff members. Please see

In addition, the facility has one teacher (certified to teach English as a Second Language (ESL)) who speaks Spanish and is on call when needed, as well as a number of staff fluent in Spanish. These translation resources will continue to ensure necessary assessment and treatment services for patients needing assistance. CSH is also in the process of recruiting an "as-needed" person to provide English lessons to non-English speaking patients as prescribed by the treatment teams. Measures will be initiated to increase the number of written treatment materials available in Spanish.

Confidentiality of such services is assured with contract and service agreement reviews as a part of our HIPAA implementation for the protection of patient identifying information and Protected Health Information (PHI).

It is noteworthy that a Licensed Psychologist fluent in both Spanish and English has worked closely with the patient interviewed by OIG staff to facilitate open communication between the patient and the Treatment Team.

6 Month Status Report: 07/01/02

Admission materials shared with patients have been translated into Spanish. Additional treatment materials (e.g., consent forms) have been identified, and work has begun on translation of those materials.

Because the facility rarely has non-English speaking patients, no formal tracking mechanism has been in place. To ensure an accurate assessment of need, a mechanism is being put in place to identify and track any patient with limited English proficiency, their spoken language and their language assistance needs.

The Office of Health and Quality Care of DMHMRSAS has convened a work group to develop strategies and plans for ensuring compliance with the Office of Civil Rights LEP requirements. A system-wide Limited English Proficiency Work Plan will be drafted after a review of survey results of both CSBs and facilities regarding needs.

CENTRAL STATE HOSPITAL
SNAPSHOT INSPECTION
JULY 30, 2002
OIG Report #66-02

Finding 1.1: Overall, the buildings toured were clean, comfortable and well maintained.

Recommendation: Preserve the current focus on maintaining a clean, odor free and comfortable environment that enhances treatment.

DMHMRSAS Response: DMHMRSAS concurs, and is gratified at the OIG's recognition of the positive advances made in the ward environments at CSH. Monitoring of all patient care area environments, both from a housekeeping and an aesthetic standpoint, will be ongoing.

Finding 1.2: Buildings 93 and 94 did not provide adequate instruction for visitors regarding entry into buildings.

Recommendation 1.2: Post instructions outside of the door regarding procedures for entry into the building. Train staff regarding security expectations.

DMHMRSAS Response: DMHMRSAS concurs. A CSH Task Force currently is re-evaluating all aspects of visitation, to include: policy formulation, family notification regarding visitation times and contraband issues, space accommodations, access to the buildings and signage. The issues of access and signage will be given priority and work on these will begin immediately. The CSH Director of Nursing will initiate a needs assessment no later than October 4, 2002. Upon completion of the assessment, an operational plan will be developed to ensure appropriate access. Signage and any necessary plant modification (i.e., wiring) will be identified and ordered no later than November 15, 2002.

A memorandum will be sent to all facility staff to remind them of the security issues related to failure of diligence in checking identification of persons entering the buildings.

Finding 2.1: Staffing patterns were adequate and consistent with the facility's expectations.

Recommendation 2.1: Maintain staffing patterns that meet facility expectations while monitoring the use of mandatory overtime to prevent staff "burn-out" and decreased morale.

DMHMRSAS Response: DMHMRSAS concurs. CSH will maintain adequate staffing levels according to hospital guidelines. Overtime will continue to be monitored, analyzed and decreased whenever possible. The amount of overtime used is driven by a number of factors, such as the number of vacancies, the number of staff out on vacation or sick leave, the number of patients scheduled for medical appointments outside of CSH, and the number of patients requiring one-to-one coverage for safety or medical reasons. More in-depth analysis is being done to differentiate between mandatory and voluntary overtime.

A former Administrator-on-Duty (AOD) RN, who due to medical problems is unable to resume former duties, has been reassigned to oversee scheduling for the entire campus and to manage all overtime use. A procedure is going to be piloted that will require documentation and monitoring of justification for overtime, with Nursing Administration sign-off. The Ward Managers and

RNCs will be re-trained to assure their competency in the use of KRONOS to determine on a daily basis when schedules need to be adjusted to avoid overtime.

Finding 2.2: Interviewed staff indicated that the use of mandatory overtime has increased over the last three months, particularly on the 2nd shift.

Recommendation: Explore the option of cross training staff facility-wide to increase the pool available for overtime shifts.

DMHMRSAS Response: There appears to be an inconsistency between the information given to the OIG interviewers and CSH data regarding overtime. The CSH KRONOS data for 3 months prior to the OIG visit demonstrates that, of the nursing staff working in Buildings 93 and 94 that evening, no staff members had completed at least two overtime shifts a week during that period as claimed. The majority of overtime shifts were voluntary rather than mandatory. Of the three staff working mandatory overtime in building 93 that evening, one had averaged 2 hours overtime per pay period in the 6 pay periods from May 10 through August 9, 2002. The second averaged 6 hours and the third 9 hours per pay period. It is unclear what the staff meant by the information that they conveyed to the interviewers.

All CSH civil patient nursing staff are cross trained across all civil patient wards. Forensic staff are cross trained across all civil patient wards in addition to forensic wards. (Civil staff are not cross trained to work in forensics due to the need to be extremely familiar with the additional security measures and due to class and compensation issues.) Although attempts are made to minimize the pulling of staff from one ward to the other, it occurs regularly in order to maximize staffing levels, provide necessary coverage and minimize the use of overtime CSH will continue to cross train staff across all civil wards and will continue to make assignments in a way that maximizes the numbers and expertise of existing staff.

Finding 2.3: The facility provides opportunities for staff to pursue career development.

Recommendation: Expand the current focus of staff training to improving staff knowledge about the benefit of training to career development.

DMHMRSAS Response: All CSH employees are given information about tuition reimbursement for career development. Information about all LPN and RN schools in the area is disseminated and the Training Department has added a federal funding application to the information.

The SVTC Workforce Development Director will continue to provide direction to the Southside campus on workforce development. She is working with the local community college to facilitate staff participation in educational opportunities. In August 2002, the college entrance exam was provided to staff. Unfortunately, only one person of the 29 on campus who took it, passed.

The *School at Work (SAW)* program is being held on campus for 2 semesters. The Department of Labor *SAW* program is specifically designed to assist staff to obtain post-high school education. CSH currently has 6 participants in the first semester. Four additional staff signed up for *SAW*, but were unable to pass the qualifying test (Test of Adult Basic Education) which is written at a ninth grade level. Because of the high failure rate on the entrance exam, CSH is

considering implementation of an 8-module remedial alternative called *Workplace Essential Skills.*

Experience at CSH has shown that career development related to DSA-level staff has involved MUCH remedial assistance, since many who are interested cannot pass qualifying tests. Therefore, CSH will continue to offer the current transition classes. Many of these staff want to expand their career prospects and are fully aware of the benefits of doing so, but are dealing with personal challenges (such as single parenthood, lack of funds, etc). A portion of them also need to first upgrade their skills before even beginning the career development opportunities.

The CSH Training Department will continue to encourage staff participation in the various staff development activities. CSH will also continue to work to provide new and innovative opportunities for training, knowledge and education that are realistic, convenient and affordable.

Finding 3.1: Record reviews revealed an integration between initial assessments, treatment planning and involvement in active treatment programming.

Recommendation: The documentation of treatment goals has significantly improved. Expand upon past successes through the development of realistic individualized treatment goals that continue to be based upon on-going clinical assessments.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the recognition of the improvements made to the documentation of treatment goals. The CSH Clinical Leaders of regularly conduct qualitative record audits and provide feedback to the treatment team members. The next phase of review will focus on realistic, individualized treatment goals based on current clinical assessment. The Clinical Leaders will continue to provide feedback to the treatment teams.

Finding 3.2: The facility has developed a mechanism for increasing patient involvement in active treatment programming.

Recommendation: The OIG commends the staff for identifying and addressing this problem. It is recommended that this information be shared with other facilities that have Treatment malls or psychosocial rehabilitation programs.

DMHMRSAS Response: DMHMRSAS concurs, and is pleased by the recognition given to this example of inter-disciplinary problem-solving related to patients' involvement in programming. On October 1, 2002, the CSH Director of Rehabilitation Services attended a statewide meeting of Rehabilitation Directors from the other state hospitals; and shared the facility's successful methods of increasing patient participation and making programs more meaningful to them.

Finding 4.1: The approval of policies and procedures reflecting changes in the human rights regulations has been delayed.

Recommendation: Address the issue of delayed decision-making by LHRC by developing alternatives for completing committee functions in the absence of a quorum.

DMHMRSAS Response: The implementation of the schedule for the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, mental*

Retardation and Substance Abuse Services was articulated in Commissioner Kellogg's memo of October 18, 2001. The schedule indicated that as of July 1, 2002, in order to provider to be in compliance with regulations, they must have their policies and procedures approved by the Human Rights Advocate. It was also required that the policies and procedures were to be submitted to the Local Human Rights Committee (LHRC) for review. The implementation schedule does not include a requirement for LHRC approval of the policies and procedures by July 1, 2002 or any other date.

Central State Hospital and the Human Rights Advocate have been working actively on the facility's policies and procedures since April 19, 2002. The policies and procedures have been reviewed and revised four times since then. To date, however, the Human Rights Advocate has not yet approved CSH's new policies and procedures. Once they are approved, the policies and procedures will be submitted to the LHRC for review.

Central State Hospital has submitted plans for the completion of the staff human rights training to the Office of Facility Operation/ Quality Assurance. These plans are not dependent on the actions of the Human Rights Advocate or the LHRC.

The revised Human Rights regulations require that a Local Human Rights Committee (LHRC) meet at least four times per year. The bylaws of each LHRC can increase the frequency of its meetings. The LHRC at CSH is one of the few that meets monthly; and this schedule was set to ensure more timely review of complaints. This LHRC unexpectedly lost several of its members in early summer 2002. The Committee cancelled its meeting in July and did not have a quorum at the August meeting. The State Human Rights Committee appointed five new members to this committee on September 6, 2002, and the CSH LHRC conducted a meeting with a quorum on September 13, 2002.

The successful functioning of the LHRC is a shared responsibility amount the providers, the Office of Human Rights and the state Human Rights Committee. The Office of Human Rights and the SHRC monitors the activities of each LHRC regularly. The State committee has the authority to reassign responsibilities to other committees and has done so when necessary.

CENTRAL VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
JULY 11-13, 2000
OIG REPORT # 27-00

Finding 5.3: Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.

Recommendation: Consider mechanisms for increasing access to the psychiatrist such that every resident currently on or in need of psychoactive medication have access to a psychiatrist a minimum of one face-to-face visit every three months.

DMHMRSAS Response: In 1991, CVTC, in order to increase access to psychiatric services for clients, entered into an agreement with Western State Hospital (WSH) for services from one of their psychiatrists. As a result of this agreement, the WSH psychiatrist spends one day every other month at CVTC to evaluate and treat clients. CVTC is initiating steps to create a second full time psychiatrist on staff. CVTC now is reviewing documentation requirements and service

processes in an effort to streamline the paperwork and increase client contact time by the psychiatrist.

5.3 6 Month Status Report 7/01/01:
CVTC created and advertised for a second psychiatrist; and at least four individuals called to make inquiries. However, as of this date, no applications have been received. There is one individual who recently indicated interest in the position and has asked for an application. The facility is hopeful. CVTC's psychiatrist met with the Medical Director at Southside Virginia Training Center (SSVTC) on April 12, 2001 to discuss and review both documentation efforts and service processes to help determine how CVTC might streamline its documentation efforts. In addition, Dr. Jeffrey Geller, DMHMRSAS consultant, conducted a site visit at CVTC on June 28 – 29, 2001, during which he met with the facility's psychiatrist and Medical Director. He made suggestions on how to improve the service process and documentation efforts. CVTC's psychiatrist and Medical Director, after reviewing the information obtained from Dr. Geller and from SSVTC, will develop plans to move to a more effective treatment and documentation model.

OIG Comment– *Interviews revealed that the facility continues in its efforts to increase psychiatric time. The contract involvement of a psychiatrist from WSH has been discontinued due to time limitations of that individual. The facility has approached several local psychiatrists in an effort to replace the one day a month availability provided by that contractor but has been unsuccessful in recruiting a candidate. Some discussion occurred with several other facilities regarding the possibility of sharing psychiatric coverage but this was not successfully completed. The facility continues to operate with one full-time psychiatrist. It was noted on the date of this inspection that approximately 40% of the residents are prescribed psychotropic medications. This finding is* ***ACTIVE.***

5.3 6 Month Status Report 01/01/02:
CVTC has not been successful in recruiting for a second psychiatrist. To date, only one application has been received. A psychiatrist was interviewed, but the interview panel did not recommend the applicant for hire. CVTC has been discussing the possibility of contracting with a local psychiatrist to provide services one day a month to the facility.

OIG Comment *– Interviews with administrative staff indicated that the second psychiatrist that had been hired by the facility resigned due to relocation. The facility plans to advertise in an effort to replace this individual. Interviews with a variety of disciplines and a review of records for behaviorally challenged individuals demonstrates that this facility's need for increased psychiatry time is critical. There are increased numbers of residents with dual diagnoses and complicated medication regimens. Three out of five of the records reviewed did not reflect that there was systematic method for assuring that appropriate follow-up occurs after intervention. This finding is* ***ACTIVE.***

5.3. 6 Month Status Report 07/01/02:
CVTC continues the recruitment for additional psychiatric services. The Facility Director has also spoken with the Director of Catawba Hospital to determine the possibility of obtaining additional psychiatric services from Catawba Hospital. Facility staff have also spoken with a retired psychiatrist from Roanoke who has indicated an interest in working for the facility on a part time basis.

Finding 8.2: Recent admissions have been more behaviorally and psychiatrically complex than in the past.

Recommendation: Residents transitioning into the community would benefit from the development of a Community Outreach Consultation Team to aid in treatment planning and implementation. This team, comprised of professionals from various CVTC disciplines, could assist community staff in the use of Applied Behavior Analysis for the development and monitoring of behavioral interventions.

DMHMRSAS Response: For mental retardation services, as well as mental health, rural communities have more difficulty obtaining and keeping staff with specialized expertise. While there are many factors contributing to this situation, a major factor is the strong economy, which creates strong competition from urban areas and from the private sector.

Applied Behavior Analysis (ABA) is a highly specialized area that has been adopted nationwide only recently. Here in Virginia, the Department began an ABA training program for facility staff just last year in collaboration with a contract with George Mason University. In FY 2002, the Department will offer this training to CSB personnel; and, although space in the course is limited, the Department can give priority to staff from rural areas.

We understand that some CVTC staff have specialized skills that either have not yet been developed, or are available only on a limited basis, in community settings. At this time we do not feel that the development of a formalized team at CVTC is necessary. However, training center staff cannot maintain a professional treating relationship with individuals once discharged from the facility. The Department continues to encourage consultation by facility staff with community providers upon request for clients discharged from our training centers. Each training center is responsible for making the availability of such consultation known both to CSBs and to other community providers. CVTC, as in the past, will continue to make staff expertise available to communities serving clients who have been discharged in order to facilitate successful, long-term community placements.

8.2 6 Month Status Report 7/01/01:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists have provided consultation to CSBs as requested, and recently the facility's psychiatrist provided consultation to an MH facility regarding a client's treatment.

OIG Comments – Interviews indicated that the admissions to the facility continue to be very complex and challenging. The facility plans on enhancing behavioral management plans with the completion of the psychologist training and the recent hire of the PhD psychologists. This finding remains ***ACTIVE.***

8.2 6 Month Status Report 1/01/02:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists and staff have provided consultation to CSBs as requested regarding clients who have been discharged from CVTC. CVTC is frequently the first point of contact for increasingly complex cases. CVTC staff often are able to divert admissions because of their familiarity with the state-wide array of services and are able to suggest more viable/appropriate options for individuals.

OIG Comment *– Interviews with administrative staff indicated that the facility continues to receive referrals for challenging and often complex individuals. It was noted that the facility has recently received a number of admission request for individuals who were acknowledged as challenging for the community but did not meet admission criteria. It was commented upon that this facility ranks in the top ten in the nation for having the highest census. Census reduction efforts alone will not serve to provide a reasonable method for assisting this facility in coming in line with the other facilities. It is recommended that the Central Office evaluate the distribution and placement of MR residents within the DMHMRSAS resource system. This finding is* ***ACTIVE.***

8.2 6 Month Status Report 07/01/02:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists and staff continue to provide consultation to CSBs as requested, regarding clients who have been discharged from CVTC. CVTC psychologists successfully completed the Applied Behavior Analysis (ABA) training program developed by the Department in collaboration with a contract from George Mason University, and three CVTC psychologists recently passed the National Behavior Analyst Certification Examination. CVTC is providing videos of the ABA training to additional staff members (i.e. center management staff, I.D. Team Chairpersons, and QMRPs). Central Office through the Division of Facility Management has convened a workgroup to address the challenging issues of the MR/MI population.

Finding 8.5: Forty-two per cent of all residents live in congregate living centers housing more than 17 residents.

Recommendation: Continue to support the goal of smaller numbers of persons living together.

DMHMRSAS Response: DMHMRSAS and CVTC support the goal of smaller numbers of persons living together. The facility has worked diligently and effectively over the past years to move out of buildings, which no longer meet the needs of clients served, and to reduce the census on living areas. In the mid -70's, CVTC had a population of approximately 3,600; today the population typically is about 655 and the number of operational beds is at 711 (effective 2/1/01). Efforts will continue to transition clients ready for discharge back to the communities.

As clients are discharged, operating beds at CVTC will be reduced until the goal expressed in the Facility Master Site Plan is achieved: a census of 293 by 2008. Efforts to divert admissions from CVTC will continue. As vacancies occur at other state training centers, CVTC clients from those localities will be offered an opportunity to transfer to these facilities, thus further enhancing decreases in clients in living centers.

8.5 6 Month Status Report 07/01/01:

DMHMRSAS and CVTC continue to support the goal of small numbers of persons living together. Since July 13, 2000, nineteen (19) clients have been discharged. Currently, four (4) clients are transitioning back to their communities. There also are ten (10) additional individuals who have already been approved/funded for waiver services.

Since July 2000, CVTC has had some success in transferring clients to a Training Center in their home community:

- two (2) clients have been transferred to Southwestern Virginia Training Center; and another client will be transferred there in August 2001.
- a client was transferred to Southeastern Virginia Training Center in June 2001; and
- a client will be transferred to Northern Virginia Training Center on July 25, 2001.

Currently, 86% of clients live in congregate living areas housing less than 17 clients. As of July 24, 2001, CVTC has a census of 636.

OIG Comment- *Interviews revealed that the facility continues in its efforts to decrease the numbers of persons in congregate living situations. This is accomplished primarily through discharges and transfers. This finding is* ***ACTIVE.***

8.5 6 Month Status Report 1/01/02:

CVTC's census as of 1/3/02 is 625. We continue to downsize through admission diversions, discharges, and transfers to other facilities (see response to Finding 8.2). CVTC continues to work with CSBs, families and providers regarding the transition of clients back to their communities. CVTC utilizes the Discharge Protocols process as a means for CSB's to focus on those clients who have been identified as "Discharge Ready". Four clients have been discharged since July, and there are 4 clients now on leave, pending discharge. There are fewer waiver slots available for client placements; however, 10 clients currently have waiver funding.

OIG Comment *– Interviews with administrative staff revealed that the facility is continuing in their efforts to decrease living unit size through transfers and discharges. The facility has established an initial target goal of having unit sizes less than 17 people, with the ultimate goal of units housing ten or less. While we recognize that the facility is working on this goal, because these crowded conditions are not in the best interest of these very impaired and intensive residents, this finding remains* ***ACTIVE.***

8.5 6 Month Status Report 07/01/02:

CVTC's census as of 7/31/02 is 609 (this includes a client on special hospitalization from Catawba Hospital who is expected to return to Catawba during the next several weeks and an emergency care admission who is expected to leave within 21 days). CVTC has continued to downsize through admission diversions and discharges. Eleven (11) clients have been discharged since 1/02/02, and there are four (4) clients now on leave, pending discharge. Additionally, two clients were transferred to other facilities, one to Catawba and one to Southeastern Virginia Training Center.

As of July 31, 2002, only 16% of all clients at CVTC reside in congregate living areas housing more than 17 clients.

- 65% of all clients live in congregate living areas housing 15 or fewer clients.
- 19% of all clients live in congregate living areas housing 16 - 17 clients.

CENTRAL VIRGINIA TRAINING CENTER
JOINT INSPECTION: DEPARTMENT FOR RIGHTS OF VIRGINIANS WITH DISABILITIES & THE OFFICE OF THE INSPECTOR GENERAL

Finding 2.3: There are an insufficient number of Rehabilitation staff employees.

Recommendation: Develop a method for increasing the presence and effect of OT and PT staff at CVTC through restructuring of current workload and use of con-tract or external professionals to build an enhanced focus on injury prevention and safety.

DMHMRSAS Response: DMHMRSAS concurs. We are confident that the actions taken to date and in process at CVTC (see above) will increase the presence and effects of PT and OT staff. At present, within existing resources, the facility's minimal goal for each therapist is to develop one physical management plan each month. By reallocating current resources, CVTC has developed plans to recruit seven additional rehabilitation staff: two (2) OTRs; two (2) COTAs; one PT; and two (2) LPTAs. As additional therapy staff are available, staff-to-patient ratios will decrease and physical management plans will increase more quickly. Staff-to-patient ratios also will be decreased as further downsizing occurs as a result of client discharges to appropriate community settings.

In order to restructure staff workloads and to improve client safety, a pilot project on team delivery of care was initiated in Lynnhaven Center in December 2000. In this pilot program, the OT/PT staff, members of the ID team and other direct care staff all work together in an integrated fashion to carry out plans and to improve outcomes for clients.

At this time, the pilot program serves 51 clients. This integrated effort has led to increased skill identification and acquisition for clients, examples of which include:

- twelve clients have had changes in adaptive eating equipment that enabled greater safety at meals.
- seven clients now regularly engage in ambulation activities outside. In addition to potential health benefits, ambulation enhances the client's capacity for community integration.
- Fourteen clients have demonstrated increased manipulation skills following supported positioning in side-lyers.

CVTC plans to expand this program to the rest of the facility.

CVTC continues to utilize area academic centers in order to promote development of new professionals. In March 2001, an OT Level II student completed her three-month internship at Lynnhaven center. Recently, CVTC has entered into a contractual agreement with East Tennessee State University relative to internships for Physical Therapy students. Other colleges have shown an interest in placing OT at CVTC for training, which the facility senior OT is coordinating. CVTC also is examining the feasibility of creating a modest stipend to students as an incentive in the future.

In order to further promote client safety, the facility Director has initiated, and will continue, meetings with the Director of Physical Therapy and Occupational Therapy staff to re-structure staff workloads and priorities. The Director of PT and OT Supervisor are developing new Employee Work Profiles which will be completed by June 2001.

CVTC will establish and begin recruitment of additional rehabilitation staff by July 1, 2001. The facility Director, in collaboration with the PT Director and fiscal staff, will explore the possibility of contracting additional therapy staff. A decision will be made regarding contract staff by July 1, 2001.

2.3 6 Month Status Report 7/01/01:

CVTC advertised for the seven additional rehabilitation positions and vacancy announcements closed July 13, 2001; there are applicants for each of the positions. The facility Director, Director of Physical Therapy and designated Occupational Therapist have discussed the possibility of contracting additional therapy staff, but would prefer to have full time staff. Once new staff are added, the facility will determine if there are additional needs.

Therapy staff continue to work with center level staff on the development and facilitation of physical management plans. At present, 121 physical management plans have been developed.

CVTC has set aside funds to provide modest stipends in the future for level two field work students. The facility will also provide housing on campus for out of state students.

OIG Comments*- During the September 2001 follow-up inspection, it was learned that the facility now advertises the full salary range for these critical positions. One full time Physical therapist and one full time Physical therapy assistant have been added to this department. On October 10, 2001, they will re-advertise for one more of each of those positions. Two full-time Occupational Therapists have been hired; one started in September and one was still in the process. Also, two, Certified Occupational therapy assistants have been interviewed and are pending offers for employment. Additionally, in an effort to help with recruitment, the facility is offering a stipend and on-site housing for OT and PT students in need of a practicum. This finding remains* ***ACTIVE.***

2.3 6 Month Status Report 1/01/02:
Additional positions for RPT, OTRs, LPTAs and COTAs have been advertised and interviews completed. Since September 1, 2001, two OTRs, one LPTA and two COTAs have been hired. Rehabilitative therapy staff continue to work with center level staff on the development of physical management plans. At present, 193 physical management plans have been developed and implemented. Each therapist's Employee Work Profile includes a minimal work requirement of completing an average of two PNMPs monthly. Additional PNMP completions are encouraged. According to facility policy, clients who have the most severe PMNP needs will be identified for priority services. APMs on each living area have been provided a Client Priority Form for PNMPs. Rehabilitation Managers have attended College Fairs in the past to attract new graduates for employment. This proved successful. An Instructor from CVTC Staff Development and Training, who handles school contracts for OT and PT, is in the process of expanding this program. CVTC now offers an OT and PT level II Clinical Placement program with provisions for a stipend and housing on site. Information brochures and applications regarding the program were mailed in December 2001 to all colleges with whom the facility has contracts. In addition, the program information and application are on CVTC's website.

OIG Comment – Interviews with both administrative and treatment staff indicated that the facility continues in its efforts to hire appropriate numbers of rehabilitation staff. Staff related that the additional responsibilities associated with the recent initiatives have also resulted in increased demands for tracking data, completing work-orders and other documentation requirements in a timely manner. CVTC should consider providing secretarial support and additional resources for automating these work tasks as a way to offset the staffing concerns to some degree. This finding is ***ACTIVE*****.**

2.3 6 Month Status Report 07/01/02:
As of July 31, 2002, the CVTC Rehabilitation Department consists of: 1 Physician who heads the department

1 Registered Nurse
1 Secretary

1 Rehab Engineer
3 Lab Mechanics

1 Director of Physical Therapy
5 Physical Therapists (full time)
1 Physical Therapist (part-time)
7 Licensed Physical Therapy Assistants
4 Physical Therapy Aides

1 Director of Occupational Therapy
4 Occupational Therapists (full-time)
1 Occupational Therapist (part-time)
11 Certified Occupational Therapy Assistants
2 Occupational Therapy Aides

In addition, the facility is currently recruiting for another Physical Therapist.

The Facility Director has met with facility MIS staff to identify technological needs. Based on that discussion, CVTC will provide additional computers and printers to therapists to assist with increased documentation requirements.

Two Occupational Therapy college students from Lenoir Rhyne College in Hickory, N.C., completed their level II Clinical placement at CVTC from May 12 - August 2, 2002.

Finding 2.6: Some residents at CVTC have had physical management treatment programs developed.

Recommendation: Re-prioritize the effort to have a physical management plan for each resident. Consider prioritizing those who have had one or more serious injuries.

DMHMRSAS Response: DMHMRSAS concurs. CVTC has established a Physical Management Leadership (PML) team which is composed of: the physical therapy staff, center staff, the Director of Staff Development and Training, the Director of Nursing, and the Assistant Director of Program Services. This team is responsible for overseeing implementation of physical management plan development throughout the facility. The Facility Director has met with Director of Physical Therapy and Occupational Therapist to emphasize the importance of physical management development and of the need to re-prioritize our efforts in this area. The Facility Director will meet with QMRPs, APMs, and center directors relative to facility efforts in physical management and injury reduction. The Director of Physical Therapy has been directed to prioritize physical management plan development for those clients who have had a serious injury. CVTC anticipates that physical management plans for all clients in need of such a plan will be completed within the next 24-36 months, as resources allow.

2.6 6 Month Status Report 7/01/01:
Please refer to the response for Finding 2.3. As of the end of May 2001, Physical Management Plans have been developed and implemented for 121 patients.

OIG Comments*- An interview with the Director of Physical Therapy revealed that he has designed a prioritization process related to injury rates, for the development of physical management plans on each consumer. To date, 150 plans have been completed and implemented, and the staff will continue to work on these at a rate of two per month until they have been completed facility wide. From now on, the physical management plans will be updated as needed, but no less than annually along with the care plans. This finding remains* ***ACTIVE.***

2.6 6 Month Status Report 1/01/02:
As of December 31, 2001, Physical Management Plans have been developed for 193 clients.

OIG Comment – *Interviews and the reviews of data indicated that approximately 200 physical management plans have been completed. Staff will continue to work on these at a rate of two per month until they have been completed facility wide. Physical management plans will be updated as needed, but no less than annually along with the care plans. This finding is* ***ACTIVE.***

2.6 6 Month Status Report 7/01/02:
As of July 31, 2002, physical management plans have been developed and implemented for 252 clients at CVTC. Physical management plans will be updated as needed, but no less than annually for each client.

Finding 2.12: Staff shortages at CVTC are critical.

Recommendation: Central Office needs to work with the leadership of CVTC to address several issues related to staff shortages.

DMHMRSAS Response: DMHMRSAS concurs. Through re-allocation of current resources, CVTC plans to hire seven rehabilitation staff (please refer to our response to Finding/Recommendation 2.3). As you know, all of our facilities are being affected by the state and national nursing shortages. The Department's Office of Human Resource Development is leading a joint facility and Central Office work group to intensify our efforts in nursing recruitment and retention system-wide. In addition, CVTC has continued its own promotional and recruitment efforts, many of which were noted in our response to the Inspector General's visit of July 2000. CVTC also continues to work diligently to help clients move to less restrictive environments. As clients are discharged to appropriate community settings, CVTC will re-allocate staff in order to reduce staff-to-patient ratios. The Department made a request during the last biennium for sufficient funding to increase staffing to CRIPA levels at all the facilities, but that request was not approved.

2.12 6 Month Status Report 7/01/01:
The Department 's Director of Human Resource Development (HRD) has established a system-wide committee to address issues relative to nursing retention and recruitment at facilities. In May 2000, the Department implemented recruitment and retention bonuses for nurses. This HRD committee, which includes Directors of Nursing from the facilities, continues to monitor hiring and retention trends as well as search for additional means by which to improve recruiting and retention. Following the direction from the HRD committee, CVTC has initiated two facility projects. CVTC recently completed a salary review for its LPNs (28) relative to internal alignment. The review resulted in an in-band adjustment for 14 LPNs. CVTC also is in the process of developing a proposal for creation of weekend shift differentials for nurses (RN & LPN). The proposal will be sent in the near future to by Central Office for approval.

OIG Comments - Since July, CVTC has hired 46 direct care staff and has offers pending to another 22 employees. They have added a shift differential to entice second and third shift workers, especially certified nurse assistants and med aides. They have also continued to emphasize the recruitment of professional staff across disciplines, especially nursing, and psychiatry. CVTC was able to hire a Ph.D. level psychologist with Behavior analysis training experience. Administration staff has also participated in a task force including community health care workers, who are also struggling to increase efforts to recruit skilled staff. This finding remains ***ACTIVE.***

2.12 6 Month Status Report 1/01/02:
DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a day-long special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the state Secretary of HHS. CVTC obtained approval for weekend differentials for nurses (RNs and LPNs) and instituted the differentials on 8/25/01. The CVTC Director of Human Resources continues to serve on the Workforce Steering Committee and attended, along with other facility staff, the December 14th Workforce Summit.

OIG Comment – *Interviews revealed that workforce issues continue to remain an issue with this facility. It was predicted that this issue will continue to be a chronic problem for this facility, particularly as a number of seasoned employees approach retirement. This finding is* ***ACTIVE****.*

2.12 6 Month Status Report 7/01/02:
The CVTC Director of Human Resources continues to serve on the Workforce Steering Committee and recently attended a Direct Care Providers' Sub-committee Meeting. The Sub-committee made recommendations regarding salaries, how to improve the public image of direct care providers, career paths, system flexibility and barriers, and recruitment and retention. CVTC recently implemented a centralized interview process in an effort to improve the timeliness of interviews and to generate a continuous flow of new interviewees and employees.

Finding 3.2: The population density (number of residents) per living area is high given the extent of disability in individuals currently residing at CVTC.

Recommendation: Continue to work toward this goal of ten persons per living unit.

DMHMRSAS Response: DMHMRSAS concurs. The Department has based its biennium Master Planning and Capital Requests for total renovation of the core CVTC buildings upon the goal of creating living areas of only ten clients. In addition, plans include moving all living areas to the first floor of each building whenever possible.

CVTC staff will continue to work toward the goal of ten persons per living unit through downsizing as clients are discharged into the community. CVTC is referring clients from other catchment areas to facilities closer to their homes as vacancies occur at those facilities. Although additional funds were requested of the state legislature, no new waiver moneys are available in this fiscal year. As a result, we anticipate that CVTC will have significantly fewer discharges this year. We are hopeful that the upcoming fiscal year will provide an increased opportunity for individuals to transition to the community.

3.2 6 Month Status Report 7/01/01:
CVTC continues to work towards the goal of ten persons per living area. Since July 13, 2000, 19 clients have been discharged from the facility. Currently, four clients are transitioning back to their communities and will be discharged soon. An additional 10 clients have been approved/funded for waiver services. The number of discharges has been significantly less during the past year due to changes in waiver funding/slots available.

OIG Comments - From July 2000 to July 2001, there has been a reduction in 33 residents at the facility and administration has reduced the operating bed capacity. However, they continue to experience difficulty in placing consumers in community settings, partially due to severity of impairments, family opposition, and less community capacity. The stated goal at CVTC continues to be 10 residents per living area and they are working toward this through appropriate placement of individuals. This finding remains ***ACTIVE.***

3.2 6 Month Status Report 1/01/02:
CVTC continues to work towards the goal of 10 persons per living area. Since September 2001, four clients have been discharged from the facility, and currently another four clients are on leave, pending discharge. CVTC staff continue to work with family members and CSB staff on discharge planning via I.D. Team meetings and transition plans. At present, twelve clients have been approved for waiver funding. The Director of Staff Development and Training, the Assistant Director for Program Services, and the Assistant Director, Community Services, attended training provided by Dr. Jeffrey Geller, Department consultant, on the new Department Discharge Protocols, which became effective 1/02/02 system-wide.

OIG Comment *– Interviews with administrative staff revealed that the facility is continuing in their efforts to decrease living unit size through transfers and discharges. The facility has established an initial target goal of having unit sizes less than 17 people, with the ultimate goal of units housing ten or less. This finding is* ***ACTIVE.***

3.2 6 Month Status Report 7/01/02:
As of July 31, 2002, only 16% of all clients at CVTC reside in congregate living areas housing more than 17 clients. ▪ 65% of all clients live in congregate living areas housing 15 or fewer clients. ▪ 19% of all clients live in congregate living areas housing 16 - 17 clients. CVTC's census as of July 31, 2002, is 609 (this includes a client on special hospitalization from Catawba Hospital who is expected to return to Catawba during the next several weeks and an emergency care admission who is expected to leave within 21 days). CVTC has continued to downsize through admission diversions and discharges. Eleven (11) clients have been discharged since 1/02/02 and there are four (4) clients now on leave pending discharge. Additionally, two (2) clients were transferred to other facilities, one (1) to Catawba Hospital, and one (1) to Southeastern Virginia Training Center (SEVTC).

Finding 3.3: The majority of wheelchairs in use and observed at the facility by the inspection team were not optimized to fit an individual's needs.

Recommendation: Work to maximize proper positioning in appropriate wheel-chairs. Outdated and dangerous wheelchairs should be eliminated.

DMHMRSAS Response: DMHMRSAS concurs. Since the December 2000 site visit, CVTC has engaged in a two-prong plan, involving assessments and staff training, to maximize proper positioning in appropriate wheelchairs. Specifically, the actions are:

- Physical and Occupational Therapists continue to work on proper positioning of clients in appropriate wheelchairs. Therapists, in developing a client's PMP, will evaluate the client's seating system and will design a. system to better meet the needs of the client. Priority has been given to clients using wheelchairs who reside in Lynnhaven Center or who have deemed to be a priority by the Director of PT. The facility's goal is to have PMPs and new seating systems for the 360 clients who require a wheelchair for mobility within the next three years.

- In March 2000, the facility held a two-day workshop for all rehabilitation staff on physical management including risk factors/management of orthopedic impairments and implementation of physical management.

- In August 2000, the facility provided a two-day course for rehabilitation staff, a *Therapeutic Seating Workshop: Principles and Assessment*. In this course, therapy staff were taught a thorough, methodical approach to seating assessment that is client centered. The presenters discussed therapeutic seating principles and how to best apply them in order to determine the primary requirements of a postural support system for seated/wheeled mobility. Participants practiced evaluation techniques and simulations with clients with supervision and guidance from the instructors.

- The facility purchased a simulator chair that was utilized in the August training workshop. Use of this chair will significantly assist therapy staff in developing appropriate seating positions for clients.

The CVTC Director will ensure that therapy staff establish formal processes by which: 1.) wheelchairs are identified for replacement and removal as soon as they become outdated or dangerous; and 2.) monitoring of timely replacement and removal occurs.

3.3 6 Month Status Report 7/01/01:
Physical Therapists and Occupational Therapists are utilizing the simulator chair regularly. Training was provided to O.T.s and P.T.s on Therapeutic Seating: Principles and Assessment. CVTC sent its first request for payment of a wheelchair to DMAS, which approved the purchase of the chair. Documentation for a second chair is ready to be submitted. The Director of Physical Therapy and Occupational Therapy will be developing a formal process by which wheelchairs will be identified for replacement. The Rehabilitation Department has a priority level for wheelchair work requests to ensure that wheelchairs that are hazardous to clients' health are removed and repaired immediately.

OIG Comments *- The rehabilitation engineer at CVTC is evaluating 360 transport chairs and has done 120 as of the September follow-up review. He has also completed requested assessments on 13 regular chairs since a new referral form has been introduced at CVTC. The Director of Occupational Therapy has also obtained a simulator chair, which is helpful in designing proper positioning of consumers in their wheelchairs. This finding remains* ***ACTIVE.***

3.3 6 Month Status Report 1/01/02:
The Director of Physical Therapy has customized a wheelchair evaluation form and distributed it to all therapists. It was reviewed and discussed during PT and OT meetings. Physical Therapists and Occupational Therapists continue to assess the 250 persons who require a wheelchair for mobility. Fifty wheelchair evaluations have been completed as of December 31, 2001. The target date for completion of wheel-chair evaluations is March 2003. CVTC has begun to access special funding available from DMAS so that custom-made wheelchairs may be obtained. Through DMAS funding, two custom chairs have been received and two additional chairs have been ordered. In addition, one client has received a state-of-the-art electric wheelchair that has a computerized program enabling the client to control chair movements via switch activation controlled by head movement. Rehabilitation therapists have submitted two additional requests for custom-made wheelchairs to DMAS for funding.

OIG Comment – *Interviews and a review of the wheelchair monthly update data completed by rehabilitation staff demonstrated that the facility is making progress towards the completion of the necessary wheelchair safety evaluations. Rehabilitation staff identified a system of prioritizing work-orders that addresses the most urgent safety needs first. As the facility is still in process of completing this task, this finding remains* ***ACTIVE.***

3.3 6 Month Status Report 7/01/02:
CVTC Physical and Occupational Therapists continue to assess the 250 clients who require a wheelchair for mobility. As of the end of July 2002, 134 wheelchair evaluations have been completed; 110 wheelchairs have been modified; and 29 requests have been submitted to DMAS to access special funding available to pay for custom-made wheelchairs. CVTC is currently planning for a follow-up workshop on "Therapeutic Seating". This workshop will provide training to new and current Physical and Occupational Therapists on how to use the mat assessment and simulation chair in order to improve seating system evaluations for the facility's physically challenged clients. The workshop is tentatively scheduled for three days in November 2002.

CENTRAL VIRGINIA TRAINING CENTER
SNAPSHOT INSPECTION
MAY 16, 2002
OIG REPORT # 61-02

Finding 1.1: Overall, the facility was clean, odor-free and well maintained.

Recommendation: Maintain current attention to a clean and orderly environment that reduces institutional appearance to the extent possible.

DMHMRSAS Response: DMHMRSAS appreciates the efforts made by CVTC to provide a clean, odor-free and well maintained environment. Be assured that CVTC's leadership will continue its efforts to maintain the environment and to reduce the institutional appearance where possible.

Finding 1.2: The facility has established a mechanism for assessing and correcting environmental hazards.

Recommendation: Sustain the current system for evaluating and correcting potential risks factors. It is recommended that the opportunities be made available for CVTC to share this model with other facilities.

DMHMRSAS Response: DMHMRSAS concurs. We appreciate that the Inspector General recognizes the strides that the facility has made in assessing and correcting environmental hazards. CVTC's safety officers continue their monitoring, and the Facility's Event Review Committee continues to meet on a monthly basis to review identified potential risks and develop strategies to address these risks. Additionally, the Risk Manager, Safety Director and Director of Buildings and Grounds work collaboratively with center staff to reduce risk factors. CVTC will ensure that these activities continue.

Finding 2.1: Staffing patterns met the facility expectations during the inspection.

Recommendation: Maintain current efforts to sustain facility staffing expectations.

DMHRSAS Response: DMHMRSAS concurs. CVTC recently has implemented a centralized interview process in an effort to improve the timeliness of interviews and to generate a continuous flow of new interviewees and employees.

Finding 2.2: There is insufficient psychiatric coverage to meet the needs of residents at CVTC.

Recommendation: Prioritize the recruitment of additional psychiatric services at CVTC.

DMHMRSAS Response: DMHMRSAS concurs. CVTC continues the recruitment for additional psychiatric services. The Facility Director has also spoken with the Director of Catawba Hospital to determine the possibility of obtaining additional or shared psychiatric resources from Catawba Hospital.

Finding 2.3: The facility has committed resources to enhance staff training and career advancement.

Recommendation: Maintain the commitment to provide career advancement training and professional development to all staff.

DMHMRSAS Response: DMHMRSAS concurs. We appreciate that the Inspector General recognizes the facility's commitment to staff training and career advancement. Please be assured that CVTC's leadership will continue to commit resources to enhance staff development and training.

DMHMRSAS and CVTC are proud of a significant staff accomplishment. Three facility psychologists recently passed the National Behavior Analyst Certification Examination. DMHMRSAS promoted and arranged for facility staff to be trained in behavioral analysis through an arrangement with George Mason University.

CVTC is a member of the Gerontology Center Consortium. On June 13-14, 2002, thirty (30) staff attended the 2002 Beard Center on Aging's Annual Conference at Lynchburg College. The workshop topics were: The Law and Elder Abuse/Neglect; Strength and Balance Training: A Hands-on Workshop, Mental Health Issues of Aging, Stress Management for the Caring Professional and Urinary Challenges of Aging.

CVTC is currently planning for a follow-up workshop on "Therapeutic Seating". This workshop will provide training to new and current Physical and Occupational Therapists on how to use the mat assessment and simulation chair in order to improve evaluation of the needs of the facility's physically challenged clients. The workshop is tentatively scheduled for three days in November, 2002.

Finding 3.1: CVTC has developed active treatment to meet individual resident needs.

Recommendation: Continue to develop active treatment that meets individual resident needs.

DMHMRSAS Response: DMHMRSAS concurs. CVTC will continue to develop active treatment that meets the needs of the clients and to provide training to staff in the area of active treatment. In April of this year, facility Charge Aides were trained in active treatment by a Ph.D. psychologist.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(FORMERLY DEJARNETTE CENTER)
PRIMARY INSPECTION FOLLOW-UP:
MARCH 30, 2000
OIG REPORT # 17-00

Finding 5.1: DeJarnette and the Central Office have made progress in the articulation of a clearer role for this facility.

Recommendation: Continue to create an identity as a quality resource for the care and treatment of children and adolescents.

DMHMRSAS Response: DMHMRSAS appreciates the Inspector General's acknowledgment of progress in the area of clarifying the role of DeJarnette Center.

At the March 16, 2000 meeting between the Deputy Commissioner and DeJarnette leadership, the mission of DeJarnette Center in providing acute inpatient psychiatric services to children and adolescents was affirmed. Guided by this mission, the role of DeJarnette Center is to stabilize children and adolescents experiencing psychiatric crisis, and prepare them as quickly as possible for either return to the community or transition to other facilities for the provision of long-term care. DeJarnette Center will continue to operationalize its newly affirmed role as a provider of acute inpatient psychiatric services. The current goal is reduce to reduce average length of stay to twenty-five days, from the average of 34 days in FY1999.

6 Month Status Report: 7/1/01
The name of the Center changed in May 2001 to become the Commonwealth Center for Children and Adolescents. CCCA will continue to serve the acute care needs of children and adolescents requiring psychiatric hospitalization when there are no other community resources available. The Center will continue to promote shortened lengths-of-stay and seek discharge options in children's communities to the extent possible. The Center will continue to dialogue with the DMHMRSAS on revisions and refinements of this role. The Center continues to be licensed under the Core Standards and is accredited by the JCAHO under the Behavioral Healthcare Standards.

OIG Comment – *Based on the May 2001 follow-up visit, it has been noted previously that this facility has history of reviewing its mission. Since it is the primary of only two state operated facilities for children and adolescents within Virginia, it is particularly important that its' role be clearly understood. The facility has scheduled a retreat to re-evaluate its' mission and values statements within the month of June 2001. It is recognized that the Center has undergone considerable change and challenge within the larger context of the changing roles of the public and private mental health care system, over the past 5 years. Since this undoubtedly influences the care available for this population it is especially critical that this issue be resolved. Interviews reveal that confusion regarding the facilities' mission is ongoing and creates anxiety among staff. This finding is* ***ACTIVE****; see finding 8.2 (OIG Report #1-99).*

6 Month Status Report: 01/01/02
Key staff of the Center participated in a mission clarification retreat in June 2001. The work resulted in a new mission statement for the facility. Although a mission statement alone does not fully clarify the Center's role in the larger child and adolescent mental health services for Virginia, it does allow us to focus our vision as the sole free-standing public mental health facility in the Commonwealth. The Center has worked with the DMHMRSAS to more clearly define its role in the Virginia mental health service delivery system. The mission of the facility as articulated by the Center and the DMHMRSAS is clearly stated to be acute intensive psychiatric in-patient treatment and stabilization services for children and adolescents. Through our many contacts with community staff and staff of other government agencies, we are able to assist in clarifying for them the role of the Center within the continuum of mental health services for children and adolescents.

OIG Comment*- Interviews with administrative staff conducted during the March 2002 inspection indicate that management staff has a clear sense of this mission, which is acute, intensive psychiatric in-patient treatment and stabilization services for children and adolescents. It is now incumbent on them to continue to develop the clinical practices, which are designed to assess, stabilize and promote successful adaptation into the community. Because this is a new mission statement, the OIG would like to monitor this issue. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02
DMHMRSAS appreciates the Inspector General's recognition of CCCA's clarity of its role in the state mental health system. CCCA staff will continue to review its internal processes to develop and maintain treatment services that meet the acute intensive psychiatric in-patient treatment and stabilization needs of the children and adolescents served by the Center.

OIG Comment –(November 2002) *At This time it is evident that within this facility staff have worked diligently to define, refine and promulgate a mission as an acute care facility. This finding remains* ***ACTIVE*** *however because at this point access to psychiatric inpatient acute care services is a critical issue for the entire Commonwealth. Given that CCCA consistently operates with a census below the bed capacity of 48, the expertise of staff at CCCA is not utilized to its fullest potential. Utilization of CCCA beds as well as access to acute services for children and adolescents throughout Virginia should become a component of statewide mental health reinvestment planning.*

Status Report: 2/28/02

DMHMRSAS/Central Office will continue to work CCCA and local providers through CSBs to develop a system where CCCA can be used as a resource to help with the needs of children and adolescents in Virginia. To this end, CCCA and other stakeholders interested in the care provided to child and adolescents will be represented at regional meetings of community providers to gather input from them on how CCCA can be best utilized. DMHMRSAS has already identified children and adolescents as a sub-group of our restructuring initiative.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(Formerly DeJarnette Center)
RESPONSE TO SNAPSHOT INSPECTION
MAY 10, 2000
OIG REPORT # 23-00

Finding 3.2: Plans to operationalize a new psychosocial rehabilitation program are expected to be implemented by June 19, 2000.

Recommendation: None at this time. We look forward to reviewing the progress of this program.

DMHMRSAS Response: DMHMRSAS appreciates the Inspector General's acknowledgement of DeJarnette's creation of a new psychosocial rehabilitation program. The proposed steps to ensure the development of activities that have a clear treatment focus (as outlined above) will assure ongoing progress in implementing psychosocial rehabilitation activities.

6 Month Status Report: 7/1/01

The Activities Staff of the Center implemented a modified treatment mall during the Summer 2000. This approach was very successful in providing active treatment offerings to all children of the Center. This program was modified in the Fall 2000 to adjust for the individual needs of clients served by the Center. The AT staff adjusted their schedules in order to provide active treatment in the evenings and on weekends. AT staff continue to implement a variety of therapeutic activities specific to the needs and treatment goals of each child.

OIG Comment: *The facility has tried different models for improving active treatment. It did initially offer a modified treatment mall during the summer of 2000, and continued the schedule of recreation and rehabilitation services once the school year resumed, during evenings and weekends. Review of materials and staff interviews, during the May 2001 follow-up inspection, reveal that the Center has returned to a unit-based model whereby regularly scheduled activities are operating the evening and weekend hours. Instead of offering these activities during the upcoming summer of 2001, the Center has contracted with local school personnel to provide an enrichment program focusing on the arts and sciences. Administration informed the team that curriculum materials have been ordered by the Activities Therapy department, and staff mentioned that they have been reviewing a Life skills curriculum that has been purchased by the facility by the SA coordinator. One concern about this menu of activities is that no structured*

curriculum has been formulated which outlines the goals and objectives for each topic. This creates difficulty in accurately evaluating whether and which of the services delivered can be demonstrated as having a useful effect on a consumers' identified problems. There is ongoing concern that these activities do not have a clear mental health acute care therapeutic focus and may not be individually tailored to meet the unique needs of a particular child. This finding is ***ACTIVE;*** *see finding 3.2 (OIG report # 1-99); finding 3.3 (OIG Report # 10-99); finding 2.4 (OIG report #17-00); 3.1 (OIG Report # 22-00).*

6 Month Status Report: 1/1/02

In the Summer 2001, the Center continued to operate the active treatment program during the evening and weekend hours as well as provide individual active treatment and group interventions during those hours so that children received the full array of interventions needed for their quick stabilization and return to their families and communities (see Finding 3.1 Status Report above). The academic enrichment program offered was to provide a school-based link for children during the month of July so that they had opportunities to build academic skills (somewhat likened to adults being provided continuing job skills development at adult facilities). The staff of this program provided a wide variety of structured, positive, and proactive groups around the topics of art (and art therapy), social studies and peer relations, language arts and cooperative learning, science/math and academic skill development, and physical education and physical health skill development. This was a very successful program with extremely positive feedback given by both children and clinical staff.

Along with the Summer Enrichment Program, groups continued to be offered that were both unit-based and cross-unit in order to provide many simultaneous opportunities for individual children to receive the groups they need or request. Activities therapy staff continue to work evenings and weekends to provide a full array of relevant active treatment interventions outside of school hours. The Center is now developing a manual that will outline the goals and objectives of each active treatment group (completion date is March 2002).

OIG Comment - *The March 2002 inspection included interviews with administrative and direct care staff; tours and observation of the activities involved in the PSR; interviews with six patients; review of educational materials; and documentation in records. The direct care staff, who perform the majority of the active treatment program functions, have a lot of enthusiasm and a willingness to learn new skills. Those interviewed questioned whether they had been adequately trained or skilled to provide the level of intervention required in active treatment.*

The amount and quality of documentation of the activities has improved. The records contain a brief description of the individual patients participation or lack thereof. The treatment plans delineate which activities are prescribed and these are related to assessment and diagnosis. All of the patients interviewed had difficulty verbalizing how the various activities in which they were engaged were linked back to their treatment plans or the reasons for their hospitalization. In comparison with the remainder of the mental health facilities throughout the Commonwealth, the psycho-social rehabilitation component of active treatment is far less individualized. When treatment is not individualized it becomes less beneficial in terms of discharge preparedness and successful community adaptation. This finding remains ***ACTIVE.***

6 Month Status Report: 7/1/02

CCCA will continue to build the active treatment programs offered to the children and adolescents served according to their individual treatment needs in coordination with the goals established by the treatment teams. CCCA strives to provide a wide array of groups that include specific interventions related to the individual treatment plans. The group interventions are determined for each individual child by the members of the treatment team, including the unit clinical director, the psychiatrist, nurses, activities therapy staff, social workers, direct care staff, and teachers in joint treatment planning and review meetings.

CCCA will work with its clinical teams to develop a process to help children more clearly understand and articulate how the various treatment activities are linked to their treatment plans.

OIG Comment *– (November 2002) Interviews with administrative, clinical and direct care staff indicated that the facility provides active treatment programming that is primarily unit-based during afternoon and early evening hours as the patients are required to attend academic programming during the day. Recreational therapists are assigned to the units during the evening hours and are the primary providers of active treatment. Active programming has not evolved at this facility in the same manner as the other facilities, which is in part due to the differences in population served. Particularly given the focus on and recent implementation of cognitive behavioral therapy, it would be reasonable to expect that more children be able to more clearly articulate their treatment goals and have a basic understanding as to how the Center meet these goals. It is clear that good work has been done in this area, however this finding remains* ***ACTIVE*** *until increased individualized treatment opportunities are available.*

Status Report: 2/28/03

CCCA will continue to develop a program wherein each individual is assessed as to what the needs are and a treatment plan is developed around this assessment that includes active treatment that is focused on person needs. To facilitate coordination with the academic schedule, by September, 2003 CCCA will implement a program that clearly identifies what activities each child is scheduled to attend (Individualized Activity Treatment schedule for each patient) that is directly related to what the treatment team has identified as the primary needs and is communicated in a developmentally appropriate manner to the client.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(Formerly DeJarnette Center)
SECONDARY INSPECTION
JUNE 9, 2000
OIG REPORT # 24-00

Finding 2.3: This patient developed difficulty clinically within several days of her discharge.

Recommendation: Assure as a part of the documented discharge planning process that every discharged patient knows what to do when emergencies arise as an outpatient.

DMHMRSAS Response: Concur. Effective October 1, 2000, the treatment team for and with each patient and her/his support system will develop an individualized back-up emergency plan. This plan will be documented on Form 226, and a copy provided to the patient/guardian and CSB. The nursing staff will discuss with the patient and support system at discharge what the plans are relative to the management of any post-discharge emergencies.

- Effective November 1, 2000, the Director of Nursing will perform audits of records to insure that this is occurring and that plans are individualized to the unique needs, strengths, support systems and risk factors of patients.
- By November 1, 2000, a system of timely feedback to staff regarding results of audits will be developed. Any individual staff issues will be addressed through supervision and other staff development activities.
- The aggregate results of the audits will be incorporated into the Department of Nursing Continuous Quality Improvement activities. The results will be reported to the Clinical Staff Executive Committee quarterly. The Clinical Staff Executive Committee will address any systems issues identified by the audits.

6 Month Status Report: 7/1/01
Emergency back-up plans continue to be discussed by a RN with each child and his/her caregiver at discharge. Back-up plans include an overview of the signs and symptoms of distress related to the child as well as options for services post discharge (including telephone numbers of service providers). The documented information is to be attached to the *Discharge Plan and Referral Summary* (DMH Form 226) as an addendum. However, monitoring has found that teams have not been consistently documenting the back-up plans on the DMH Form # 226. Nurses at the Center have been given this responsibility to monitor successful implementation of this process. RNs will audit the process and report findings to the Unit Treatment Teams and the CSEC on a quarterly basis. Aggregate results of the data will become part of the Nursing CQI process and will be reported to the CSEC on a quarterly basis.

OIG Comment *- During the May 2001 follow-up visit, the review team was informed by the administration that emergency preparedness plans were now discussed routinely at discharge and documented on the discharge planning form. However, the randomized review of records, demonstrated no documentation of these plans for discharged clients. It is therefore impossible, from a risk management perspective, to assess whether this is, in fact, occurring. This finding is* ***ACTIVE****.*

6 Month Status Report: 1/1/02

The Center nurses have been routinely discussing emergency procedures and providing community resource information with families at the time of the child's discharge. In addition, social workers discuss each child's discharge needs and available supports, including emergency procedures, with the receiving CSB. However, chart monitoring indicates that nurses have not been documenting the interactions. This issue continues to be addressed with nursing staff.

Documentation of information regarding emergency and other transition plans is required for the revised *DMH 226 Discharge Planning and Referral Form*, as part of the newly formulated Departmental Discharge Protocols [implemented 1/02/02]. The 226-form includes specific sections for both a Transition Plan and a Crisis Plan. CCCA staff received training by Dr. Jeffrey Geller, Department consultant, on the Discharge Protocols, which included documentation expectations. Monitoring of compliance with the new discharge forms and protocols will be conducted.

OIG Comments*- During the March 2002 inspection 10 discharge records were reviewed in addition to interviews with administrative and clinical staff. The majority of charts surveyed, contained emergency preparedness plans in accordance with the new procedures. It is clear that progress has been made, however, it remains our opinion that 100% of the charts should have a clear indication as to emergency preparedness plans that the child can understand. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02

The *DMHMRSAS Discharge Protocols for Community Service Boards and State Mental Health Facilities* were implemented on Jan. 2, 2002. The Protocols include a new form, *Needs Upon Discharge/Discharge Plan Form (DMH-226, Revised*). CCCA has implemented use of both the Protocols and the Discharge Plan Form. The discharge form includes post-discharge crisis planning which is developed by the CSB, the facility treatment team and family or significant other.

Center staff is monitoring compliance with the Protocols and the discharge plan. CCCA will address areas of non-compliance, especially when patterns are identified, on an on-going basis. Crisis planning in particular will be monitored, with CCCA maintaining the goal of 100% completion rate for crisis plans as well as maintaining the goals of clarity and understanding of each plan by the children/adolescents and their families.

OIG Comment – (November 2002) *It is important, particularly as this facility provides shorter-term care, for patients to have a clear understanding and PARTCIPATE in the developing of a crisis plan, which contains clinical contingencies, if the patient becomes unstable during the transition following hospitalization. Plans of correction submitted by this facility and accepted by the OIG outlined a process by which RNs would review crisis plans with patients AND their families at the time of discharge and provide documentation as to the completion of this process. This process was well underway and improvements in documentation were noted.*

However, recently implemented statewide discharge protocols have clouded the facility role in this process. Even though the discharge protocols indicate that crisis plan, if needed, are to be developed by the CSBs, the OIG believes that these plans were never meant to release clinicians or the facility from assisting the patient in verbalizing a plan that outlines actions that can be implemented by the patient using both their natural support systems and treatment providers This finding remains ***ACTIVE*****.**

Status Report: 2/28/03
CCCA will continue to work with the CSBs to develop discharge plans that have crisis plans indicating what the client should do in the event of crisis post - discharge. The statewide discharge protocols guide that facilities are responsible for identifying the needs of a client at discharge, while the CSB is responsible for identifying resources to support those needs. This does not mean that each does not provide feedback related to the entire discharge plan and crisis plan. The treatment team remains integral to the process of assessing the need for a crisis plan and client and family understanding of a crisis plan. CCCA will endeavor to insure at discharge that each client and/or family knows what to do in case of a crisis.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
SNAPSHOT INSPECTION
MARCH 6, 2002
OIG REPORT #56-02

Finding 3.1: Patients have access to education and evening activities.

Recommendation: Enhance evening activities designed to meet the individual treatment needs of the patients. Review the practice admitting adolescents to the children's units.

DMHMRSAS Response: DMHMRSAS is committed to the provision of active treatment and age-appropriate treatment for all clients in our system. CCCA provides active treatment in the form of psycho-educational groups, recreation therapy, music therapy, and substance abuse groups in the evening and during weekends. CMS (formerly HCFA) guidelines require a minimum of 21 hours of active treatment per child per week (not including individual and family therapy). The Center consistently exceeds that 21- hour minimum of active treatment hours. The staff members involved in planning and leading active treatment groups are also members of the clinical teams for the children served. They determine the need for groups based on treatment goals and objectives written for each individual child as established by the clinical team. Because the Center serves a wide variety of children of different ages, including children with mental retardation and (at times) autism, it has been necessary to plan a wide variety of interventions for all children at the Center. The CCCA Activities Therapists and their supervisors have developed a comprehensive listing of all the types of groups currently offered at the Center. They plan additional groups as indicated by the changing needs of the children. The Center will continue to monitor the number and types of active treatment groups offered to children. New groups will be formed as needs arise.

CCCA has two units with 12 beds each for a Children's Program and for an Adolescent Program, for a total of 48 beds. Placement on these units is determined by age, developmental level, and bed availability. The Admissions staff consults with program staff to the extent possible in determining where a child should reside while at the Center. Sometimes, when beds on specific units are full, the Center will place a child on a unit with an available bed. This may mean that a 16-year-old adolescent may reside on the pre-adolescent unit that typically serves children from ages 12 to 14. Likewise, if the Children's Program units are full, a 13-year-old child may need to reside on an Adolescent Program unit which typically serves children ages 14 to 17. When these mixes occur, the clinical team for the child works with the other teams to plan group interventions and activities with his/her chronological peers to the extent possible. Children admitted to a different age unit may be relocated to a more age appropriate unit when a vacancy occurs, as determined by needs of the child and therapeutic progress. This occurs in communication with the child, the family, and others involved in the care of the child.

6 Month Status Report: 07/01/02

The CCCA Activities Therapy and other staff continue to provide more than the minimum of 21 hours of active treatment per child per week. The AT staff continues to discuss treatment needs of individual children with clinical treatment team members and plan interventions for individuals that are appropriate to their needs. The Clinical Staff Executive Committee has reviewed and made recommendations to the comprehensive listing of all groups offered by the Activities Therapy and Nursing staff of the CCCA. This list serves as a menu of options available for group and individual interventions with children as determined by their respective treatment teams The management team of CCCA will continue to monitor though quarterly reviews by the Clinical Program Services staff.

Admissions staff continues to work with unit clinical teams in determining the best placement of newly admitted children and adolescents. In the infrequent event when the CCCA must place a child or adolescent on a unit with different aged children or adolescents, the staff consult with one another to provide the best therapeutic care that meets the needs of the individual. The staff of CCCA assess the individual's needs for safety and security as well as assess the level of dangerousness toward others. The staff determines the best placement option taking into account multiple variables.

OIG Comment *– (November 2002) Interviews with administrative, clinical and direct care staff indicated that the facility provides active treatment programming that is primarily unit-based during afternoon and early evening hours as the patients are required to attend academic programming during the day. Recreational therapists are assigned to the units during the evening hours and are the primary providers of active treatment. Active programming has not evolved at this facility in the same manner as the other facilities, which is in part due to the differences in population served. Particularly given the focus on and recent implementation of cognitive behavioral therapy, it would be reasonable to expect that more children be able to more clearly articulate their treatment goals and have a basic understanding as to how the Center meet these goals .It is clear that good work has been done in this area, however this finding remains* ***ACTIVE*** *until increased individualized treatment opportunities are available.*

Status Report: 02/28/03
CCCA will continue to develop a program wherein each individual is assessed as to what the needs are and a treatment plan is developed around this assessment that includes active treatment that is focused on person needs. To facilitate coordination with the academic schedule, by September, 2003 CCCA will implement a program that clearly identifies what activities each child is scheduled to attend (Individualized Activity Treatment schedule for each patient) that is directly related to what the treatment team has identified as the primary needs and is communicated in a developmentally appropriate manner to the client.

Finding 3.2: The observed use of restraints was inconsistent with the current D.I. recommendations that restraints either be utilized for acute emergency management or as a formalized part of an approved behavioral Management program.

Recommendation: Reconcile the existing the Departmental Instruction on Seclusion and Restraint with practice at CCCA. Consider consultation on particularly challenging individuals with in-state resources such as behavioral consultation teams in place at other facilities.

DMHMRSAS Response: The Department appreciates the concern expressed regarding the use of mechanical restraint with a specific adolescent. The Departmental Instruction on seclusion and restraint was written primarily for adult populations served at the psychiatric hospitals in the DMHMRSAS system. Federal standards for seclusion and restraint for children differ. Therefore, the Center was granted a waiver from the Departmental Instruction in 2001. The seclusion and restraint policy of the Center was developed with Central Office staff and includes all of the requirements established by JCAHO, the State Human Rights Regulations, and the federal government.

In November 2001, the DMHMRSAS issued a revision of the State Human Rights Regulations. In February 2002, the Center admitted the adolescent referenced in the OIG report. This adolescent had an extremely violent history both at the Center and at the adult jail in which he resided prior to his admission to CCCA. When determining the intervention needs for this individual, the Center determined that mechanical restraint would be used on an emergency basis to protect others from this actively psychotic and assaultive adolescent. When the level of dangerousness of this adolescent did not subside, the treatment team found the need to continue the use of restraint with the individual. The safety of others as well as the rights of others to be protected from harm were strong clinical considerations since significant physical injury to others had resulted from previous assaults by this adolescent.

The Center's internal seclusion and restraint policy prohibits the use of seclusion or restraint as part of a behavior management plan. Therefore, when the treatment team brought forth a draft behavior management plan that used restraint, the Center's behavior management committee rejected it. In exploring the requirements of the new State Human Rights Regulations, the Center determined that use of mechanical restraint could continue if the team followed regulation 12 VAC 35-115-110.C which provides three options for the use of seclusion or restraint: 1) emergency use; 2) use as determined and documented by a qualified professional involved in providing services to the individual; or 3) as part of a behavior management plan. The Center

staff determined that the situation for this adolescent fit the criteria stipulated under 12 VAC 35-115-110.C.2. a through d. The unit psychiatrist and other members of the clinical team initiated mechanical restraint based on these criteria as well as a comprehensive assessment of his functioning. All monitoring and documentation of the use of the intervention meets the requirements established by CCCA policy, JCAHO and federal standards, and the State Human Rights Regulations. Over time, as this adolescent's condition improved, he was slowly released from mechanical restraints. This adolescent was ultimately discharged back to the adult jail. The Center will continue to strive toward the reduction of the use of seclusion and restraint with its patient population and will continue to meet the requirements for the use of these procedures for its specific population of clients.

6 Month Status Report: 07/01/02

Through the Restrictive Interventions Committee, a standing committee of the Clinical Staff, CCCA will continue to monitor the use of seclusion and restraint and will continue to meet state, federal, and JCAHO requirements for use. Recent record reviews of cases involving use of seclusion and restraint were made by Dr. Jeffery Geller, consultant to the DMHMRSAS, as part of a comprehensive assessment of Center services and processes requested by the DMHMRSAS; and through a scheduled 'mock' JCAHO survey by a state expert. Both site visit reports stated that the Center demonstrated significant compliance to state, federal, and accreditation requirements for the use of seclusion and restraint. Dr. Geller's report indicated that CCCA has a seclusion and restraint policy that meets professional standards. He suggested that CCCA fine tune the process for tracking threshold requirements for reviewing seclusion and restraint contemporaneous with treatment. The Restrictive Interventions Committee at the CCCA has responsibility for monitoring this suggestion.

OIG Comment: *Members of the OIG team meet with Dr. Reinhard to discuss this case and to request clarification. This finding will remain* ***ACTIVE*** *until clarification regarding this interpretation of near continuous restraints without the development of a behavioral management plan is reviewed.*

Status Report: 02/28/03

CCCAs policy for seclusion and restraint is set at a higher standard than required by the DMHMRSAS DI on seclusion and restraint in that it does not recognize the use of seclusion or restraints as part of a behavior management program. It has been the intent of CCCA to convey a philosophy reflective of the idea that seclusion and restraints is used only as an emergency response where less restrictive alternatives have failed. CCCA understands that there are occasions when seclusion or restraints must be used for the safety of all parties as outlined in the DMHMRSAS State Human Rights Guidelines, Departmental Instruction and in compliance with federal Medicaid regulations. The Center has worked hard to reduce the use of seclusion and restraint while providing a safe environment both for the patients and staff and is committed to continuing these efforts. The recent JCAHO survey resulted in a score of 99% compliance with no type 1 recommendation is one testimony to the continuing efforts to decrease seclusion and restraints.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
SNAPSHOT INSPECTION
NOVEMBE 19-20, 2002
OIG REPORT #71-02

Finding 1.1: Overall, staffing patterns were consistent with facility expectations.

Recommendation: None. This facility has had the good fortune to be able to attract many individuals with at least a Bachelor's Degree in the position of direct care assistants. It is often difficult for facilities to be able to maintain staff with this level of education within these positions because of the nature of the work and the associated compensation. The Commonwealth Center provides staff with opportunities to increase both their experience and knowledge base, which enables them to enhance their skills.

DMHMRSAS Response: DMHMRSAS appreciates the OIG's recognition of CCCA 's effort to attract the best-qualified individuals available for all staff vacancies.

Finding 2.1: CCCA provides opportunities for the patients to maintain their educational status as well as participate in active treatment.

Recommendation: This facility has completed a number of refinements to the provision of active treatment. Most notable has been the introduction of more formalized and structured psycho-educational substance use and abuse programming. As noted during the follow-up reviews conducted during this inspection, this service has become an integral part of active treatment programming. CCCA has been able to hire an additional staff member to conduct groups. Active programming remains primarily unit-based, which is different than active treatment provision at the other facilities, but this is a function primarily of the population served by the facility.

DMHMRSAS Response: CCCA will continue to develop active treatment based on needs of clients including the provision of education regarding substance abuse for clients who have been assessed to be in need of this education.

Finding 3.1: Overall, the facility was clean, comfortable and well maintained. Efforts at making this setting appear more home-like were noted.

Recommendation: Review staff's understand that patients are not required to maintain their bedrooms in an orderly fashion due to human rights issues. This was addressed during a previous OIG inspection and follow-up. It was indicated in the plan of correction that the facility would clarify expectations that all patients would be held accountable for maintaining their bedrooms as part of the unit expectations.

DMHMRSAS Response: CCCA will establish unit expectation that individual patients have responsibility for maintaining their bedroom areas in a responsible manner based on their physical and mental abilities to do so.

Finding 4.1: Behavioral Programming at CCCA is primarily integrated within the unit management system.

Recommendation: None.

EASTERN STATE HOSPITAL
RESPONSE TO PRIMARY INSPECTION
SITE VISIT OF SEPT. 25-26 & OCT. 3, 2000
OIG REPORT # 31-00

FINDING 1.2: Challenging placements were identified as one of the primary issues facing the human rights advocates providing services for the acute admission unit, Building 2.

Recommendation: Maintain dialogue with facility, Central Office and the community regarding issues associated with community re-integration.

DMHMRSAS Response:

6 Month Status Report: 7/1/01
Eastern State Hospital has been participating in on-going meetings with Central Office and HPR-V CSBs to resolve barriers to placement and improve the discharge planning process. Utilization review of 100% of the patients in Admission Building is being conducted weekly to identify discharge ready patients. Discharges have increased as a result of these efforts. Lengths of stay have also been reduced.

OIG Comment - *Interviews revealed that this facility continues to deal with challenges associated with being able to match patient needs with available community resources. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02
ESH is implementing the new statewide Discharge Protocol by January 2, 2002. The initial hospital training has been completed and the Clinical Operations Director is working closely with Central Office to continue to improve the discharge planning process. During this report period clinical social workers previously assigned to the Hospital Community Liaison/Resource Department were reassigned to programs, with the focus on preparing patients for discharge and identifying needs to be addressed upon discharge. This action was the result of statewide implementation of the Discharge Protocol that places responsibility for discharge resource identification on CSBs. The median LOS was reduced by five days in October hospital-wide and it is currently 14 days in Acute Admissions. The Clinical Social Work Director continues 100% utilization review with the Clinical Operations Director to maintain and/or decrease LOS.

OIG Comment *– Interviews indicated that the facility has demonstrated initiative in addressing difficult placement issues with respect to substance abuse and mentally retarded patients. As outlined in the status report, OIG team members were informed of increased community contact regarding placement issues and a restructuring within social work for focusing on preparing patients for discharge. These actions coupled with the initiation of the statewide Discharge Protocols by all facilities are evolving. This finding is ACTIVE.*

6 Month Status Report: 07/01/02
The Clinical Operations Director meets monthly with the case manager liaisons from the nine CSBs served by ESH, the Program Social Work Directors, and Central Office staff, to problem-solve and improve the Discharge Process. The Utilization Review Coordinators and Clinical Operations Director collaborate on all U.R. denials that effect discharge. There is ongoing review of all patients in the Hospital who are clinically ready for discharge and a new computer program has been developed and is in the process of being implemented to provide daily updates on all patients regarding clinical discharge ready status. The May 2002 Management Information Systems Report showed an increase in the number of discharges from January 2002 to May 2002.

Finding 2.2: Continuous observation of patients in seclusion is not a current practice in Building 2.

Recommendation: ESH needs to review its policy regarding seclusion and update it in terms of consistency with new departmental instructions.

DMHMRSAS Response: ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints,* is currently under revision to be consistent with Departmental Instructions and policies; and it will be finalized and implemented January 1, 2001.

6 Month Status Report: 7/1/01
ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints,* has been revised and coordinated with all required clinical committees. As required by Departmental Instruction, a draft copy was forwarded to DMHMRSAS for approval prior to implementation. Policy will be implemented immediately after Central Office review. Estimated completion date is August 15, 2001.

OIG Comment - *Interviews and observations indicated that the facility continues the practice of fifteen-minute observations of patients in seclusion instead of continuous observation. On the date of the inspection, a patient in seclusion was noted by the OIG team to be lightly tapping on the door asking if someone could "please talk to me". Although he appeared to be calm and appropriate, there was not a staff member present to observe or assist him. This practice places the patient at risk for harm and the facility at risk for liability of actions that occur while the patient is not being observed. One staff member volunteered that when the patient was in*

seclusion, it was the only "break" they had from him. Record reviews demonstrated that he was a challenging patient and often required one on one due to impulsive aggressive behaviors. Staff indicated that delays from the Central Office in approving the draft policy governing seclusion and restraint prohibited its implementation. This finding is ***ACTIVE.***

6 Month Status Report: 1/01/02
The facility has drafted a new policy TX-450-35 has been completed and revised in accordance with the new DMHMRSS DI. The policy has been disseminated and is currently being taught to all direct care employees.

OIG Comment – *Interviews and observations during the follow-up tour revealed that staff do not practice continual observation while patients are in seclusion. To the knowledge of the OIG, ESH is the only DMHMRSAS mental health hospital that does not practice continual observation. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
Staff members have been informed on the need to adhere to the practice of continual observation of secluded patients. We have made the changes to our policy and staff are continually monitoring seclusion and entries recorded on the patient monitoring sheets. Quality Management monitors six items on the sheets and results of the monitoring show an average of 97% of observation activities are documented on the patient monitoring sheets.

Finding 2.3: There was not any documented evidence that routine debriefing of patients regarding seclusion events occurs.

Recommendation: Formalize the process of post-seclusion debriefing of both staff and patients including procedures for documentation. This is consistent with new Departmental Instructions.

DMHMRSAS Response: The expectation and procedures for patient and staff debriefing following all incidents of seclusion and restraint has been included in draft ESH Policy TX-450-35, *Emergency Use of Seclusion or Restraints*, as noted above, which will be implemented on January 1, 2001. In addition, the Nursing Practice Council will update the Nursing Standard Operating Procedure to include debriefing guidelines and documentation standards. All staff will receive in-service training in these guidelines and standards.

6 Month Status Report: 7/1/01
Revised policy is pending review and approval by the Central Office, Office of Health and Quality Care. The Nursing Practice Council developed a Seclusion/Restraint Debriefing Form/TPC Note to be used as a debriefing tool following episodes of seclusion or restraint.

OIG Comment - *The facility is developing a form to be placed in the patient record that will provide a format for the routine documentation of debriefing with the patient following the use of seclusion and/or restraint. There was limited evidence in the records reviewed of efforts to*

conduct debriefings. Staff have reviewed this process and explored several options for conducting and documenting debriefings. This finding is ***ACTIVE.***

6 Month Status Report: 1/01/02
Debriefing forms have been developed as part of our current Emergency Seclusion and Restraint Policy. Utilization Review Coordinators are monitoring the debriefing process by reviewing 100% of the seclusion or restraint events. Results of these reviews are reported at the monthly Quality Improvement Council meeting and to the supervisors of the patients' ward.

OIG Comment – *Chart reviews has not indicated that the new form has been fully implemented within the facility. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
Full implementation has occurred of the Seclusion/Restraint Debriefing Form and more attention is being undertaken to documentation of debriefing activities to assure all episodes are fully debriefed as required in the policy. Monitoring of debriefing activities currently shows a 89% compliance rate in acute admissions and a 100% compliance rate in psychosocial rehabilitation areas. Tracking shows monthly improvement in compliance rates.

Finding 3.6: Patients, dually diagnosed with both mental illness and mental retardation present a placement challenge for the facility.

Recommendation: Work with the Central Office in exploring alternate methods for meeting both the treatment and placement needs for this population.

DMHMRSAS Response: DMHMRSAS continues to develop strategies to better meet the needs of the MI/MR population. The Director of Health and Quality Care, has discussed this issue in-depth with the ESH Medical Director and with other state facility Medical Directors; and they continue to explore and disseminate best practices for treating this population. The Central Office of Mental Retardation also has provided technical assistance to both facilities and communities in addressing treatment and placement needs for the MI/MR population.

DMHMRSAS supports ESH's ongoing efforts to improve treatment for this population, which includes:

- Designating one facility social worker to work exclusively hospital-wide with the MI/MR population regarding placement issues.
- ESH treatment teams aggressively referring appropriate MI/MR patients to the Behavioral Management Committee for individualized treatment plans to address problematic behaviors, which impede patient placement in the community.
- ESH staff continuing to attend, training on the treatment and resources for this population.
- ESH Liaison Director attending monthly HPR-V meetings of the CSB MR Directors to enhance facility and CSB linkage for treatment and discharge issues.

- ESH obtaining regular consultation from, a nationally recognized MR Behavioral Consultant, as needed for specific dually diagnosed patients using tele-conference technology.

6 Month Status Report: 7/1/01
Upon admission of an MR patient, the DMHMRSAS Office of Mental Retardation, is notified via letter providing pertinent information, such as initial diagnosis on admission and results of any I.Q. testing available. A quarterly report is submitted denoting information on the above patients, including date of discharge, if applicable. Barriers to discharge continue to be aggressive patient behavior and waiver placement. A Clinical Social Worker was assigned on January 15, 2001 to track the dually diagnosed MI/MR population, inpatient adult population, and to promote facilitation of timely and appropriate discharges by working closely with the treatment teams and MR case managers. Facility staff attended MR training workshops, including Medicaid waiver training conducted by Behavior & Assessment Consultants. The Liaison Director and the MR/MI Social Worker have visited resource fairs to meet with service providers. The Clinical Operations and Liaison Directors attended individual services plan training and shared information with the MR/MI social worker and CSB staff. Training enhanced the hospitals ability to identify, pursue, and secure waiver entitlements. A monthly report is prepared listing patients, diagnoses, and discharge efforts during the reporting cycle. The Community Liaison Director attends monthly HPR-V MR Director's meetings to enhance/increase facility and community communications concerning the MI/MR population. CSB Directors now actively seek alternative placement for MR patients. A draft agreement between the Department and the CSBs will address the screening and placement needs of clients with MI/MR diagnosis. For individuals with dual diagnosis of MI/MR, both the admitting Mental Health Facility and the region's Mental Retardation Training Center shall confer to determine which institution can best serve the individuals needs.

OIG Comment - – *Interviews indicated that this population continues to present a significant challenge to this facility. Administrative staff indicated that the majority of patients currently admitted and identified as exhibiting high-risk behaviors have both a diagnosed mental illness and mental retardation. This was also confirmed during staff interviews and record reviews. Placement continues to remain a significant difficulty because of the behavioral challenges. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02
Currently ESH has 22 adult patients with a Mild to Moderate Mental Retardation diagnoses. The new Discharge Protocol should assist in providing an ongoing mechanism to track this patient population relative to discharge. The Facilities Clinical Operations Director will continue to gather monthly progress reports on this

population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility.

In addition, a DMHMRSAS Central Office work-group has been established comprised of representatives of MR and MH facility directors and CO MH and MR and operations representatives to discuss strategies to address the growing population. A decision should be made by the Spring of 2002 regarding what avenues the Department will take.

OIG Comment – *Interviews with staff indicated that this continues to be an ongoing problem. The facility continues to make contact with appropriate community providers in order to foster improved placement options. Resolution of this problem will require the Central Office address resources across the state for this challenging population. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02

Currently ESH has 16 adult patients with a Mild to Moderate Mental Retardation diagnosis. The new Discharge Protocol is used to provide an ongoing mechanism to track this patient population relative to discharge. The Facility's Clinical Operations Director continues to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility. In addition, a DMHMRSAS Central Office Task Force has been established, comprised of representative of MR and MH facility directors, Central Office MH and MR, and operations representatives to discuss strategies to address this growing population as well as community and CSB representatives. This Task Force has met once with the Director of the National Association for Duel Diagnoses, who provided a presentation on promising programs. The Steering Committee of that group is now meeting to identify statewide programs and to consider a Statewide conference and regional planning to address this population.

Finding 4.2: Nursing staffs frequently work mandatory overtime to meet current staffing patterns.

Recommendation: Continue to explore alternate ways of meeting the staffing needs of the facility while lessening the amount of mandatory overtime for staff.

DMHMRSAS Response: DMHMRSAS concurs and shares this concern about reducing mandatory overtime. At this time, the Office of Human Resource Development has identified nursing recruitment and retention as a systemic issue among all our facilities. Central Office, therefore, is developing a centralized approach to this problem in order to raise the level of our efforts in nurse recruitment and retention system-wide.

The Central Office Director of Human Resource Development, is heading a joint facility and Central Office work group for that purpose. The Director is consulting with each facility's Directors of Human Resources and Nursing Services to coordinate potential initiatives.

In addition, ESH over the past months has been active in addressing the mandatory overtime issue through creation of a "Nursing Task Force" in September. This task force focuses specifically on nursing recruitment and retention issues. Accomplishments of this Task Force thus far include:

1. Meeting with nursing staff on all three shifts at the Change of Shift reports to explain Task force goals and objectives.

2. Developed, distributed, and reviewed the results of a survey sent to all nursing staff to help address recruitment and retention. The survey sought to identify specific factors of dissatisfaction among the nursing staff as well as to identify ideas and suggestions for improvement related to retention. Completed in late November 2000, the survey identified mandatory overtime and staff scheduling as the major concerns. The Task force is actively seeking viable solutions to staff concerns.

3. Developed several committees to evaluate and make recommendations regarding key staffing issues, i.e., scheduling staff by patient acuity by program rather than by HPPD.

4. A nursing Intern Program is being developed and will be advertised in the *Virginia Gazette* and the *Daily Press* after the first-of-the year in an effort to recruit nursing students. The colleges targeted will be: Hampton University, Christopher Newport University, Old Dominion University, and Norfolk State University.

In addition, on Saturday, December 2, 2000, ESH Human Resources and the Department of Nursing conducted an Open House for Recruitment of Nursing Service Employees. On-the-spot applications were accepted, and interviews were conducted. Tours of the facility were offered to those interested applicants**.** Fifty applications were received (out of 66 attendees), and 45 staff were hired. The new hires included nine Registered Nurses, seven Licensed Practical Nurses, and 29 Direct Service Associates.

6 Month Status Report: 7/1/01

The Director of Nursing is on three task forces to seek solutions to the recruitment/retention issues that affect licensed nursing and health services care workers. Listed are efforts underway to meet our staffing needs while attempting to reduce mandatory overtime for classified nursing staff:

1. Nursing Taskforce was established March 2000.
2. Bonus for working voluntary overtime began December 2000. Lists were posted in each building began January 2001.
3. Attendance bonus for DSAs began in December 2000.
4. Pilot use of voluntary overtime to reduce number of hours of unplanned leave in Medical Services began December 2000.
5. Nursing Open Houses were held in January and April 2001. Another is planned for August 25, 2001.
6. A Referral Bonus Plan and in-band adjustment recommendations were sent to Central Office Human Resource Department for approval, June 2001.
7. Developing a partnership with Thomas Nelson Community College to provide nursing related courses on ESH campus. Anticipated beginning date of classes is in fall 2001.
8. Nurse internship program began May 2001. Four RN applicants were hired in June 2001.

The Director of Nursing is a member of the DMHMRSAS Nurses Executive Group with Central Office Human Resources Office to address recruitment and retention issues at the state level. She is also a member of the Nursing Summit Taskforces on general recruitment, retention issues and recruitment of minority nurses in Virginia. The Nursing Taskforce Committee has been disbanded and a Recruitment and Retention Committee has been established. The first meeting is scheduled for August 7, 2001

OIG Comment - – *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

The following efforts have been made to help with nursing moral and retention:

1. Meetings were held with the nurses on all three shifts at the change of shift to discuss issues impacting nursing care.
2. As a result of the Nursing Service survey, voluntary overtime is encouraged and has increased. The survey reviewed issues such as recruitment and retention and the use of overtime.
3. ESH indicated a special taskforce was developed and reviewed three acuity systems for patient care. Staffing by patient acuity continues to be explored.
4. The Nursing Intern Program for nursing school students entering their senior year resulted in the recruitment of seven (7) nursing interns into the program in June 2001. The students returned to school in August 2001. The brochures (under revision) will be mailed to all nursing schools in Virginia in January 2002 for the summer 2002 program.

Open Houses were also held on Saturday, March 24, 2001 and Saturday, August 25, 2001 to recruit and interview for Nursing Services.

6 Month Status Report 7/01/01 Updates:

1. The attendance bonus for DSAs continues.
2. The bonus for working voluntary overtime continues.
3. The pilot use of voluntary overtime to reduce the number of hours of unplanned leave in Medical Services has been successful.
4. The Nursing Open House planned for August 25, 2001 was held and was successful in recruiting DSAs.
5. The referral bonus plan for RNs, LPNs and DSA IIs was approved.
6. The nursing taskforce has been dissolved after completing the task of reviewing the overtime and recruitment issues which are being reviewed through the statewide taskforce.
7. An RN applicant through the recruitment process was hired July 30, 2001.

8. The partnership with Thomas Nelson Community College is currently on hold. Presently the College is reviewing their program accreditations

The Recruitment and Retention Committee meeting scheduled for August 7, 2001 was canceled due to the resignation of the Director of Nursing.

However, DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a day-long special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment *- Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. Nursing staff indicated that community facilities had become increasingly competitive making working "for the state" less attractive. In addition, staff interviewed related that voluntary overtime although viewed as separate from mandatory overtime results in nursing staff working as much as 16 hours of overtime per week. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

The facility is in the process of preparing to offer two (2) courses on ESH campus in collaboration with several administrative staff members from Thomas Nelson Community College. The response has been overwhelming in terms of interest by ESH staff. There are currently four (4) intern students from the surrounding colleges in ESH Summer Nursing Internship Program. One (1) RN who attended the Internship Program last summer has been hired. This individual was motivated to become a certified nurse's aide after completion of the program last summer and has been working as a DSA II while completing her course requirements. Although minimal, this success is as a result of the Internship Program.

Meetings have been held with nurse management to clarify the use of voluntary overtime versus mandatory overtime.

Finding 8.1: Recruiting and retaining nursing staff has proven to be extremely difficult facility-wide.

Recommendation: Work with the Central Office in developing solutions to the overall and on-going shortage of nursing personnel at this facility.

DMHMRSAS Response: Concur. See response to Finding 4.2.

6 Month Status Report: 7/1/01
Recruitment and retention of licensed nursing staff is a nation-wide issue that we are addressing at the local and department level. See response to Finding 4.2.

OIG Comment - *– Please refer to response in Finding 4.2. This finding is* ***ACTIVE.***

6 Month Status Report: 1/01/02

The Human Resource Department provided the Office of Health and Quality Care in Central Office, with a notebook of studies and an update of activities to enhance recruitment of nurses at ESH. These include:

1. An In-Band Adjustment for Retention of 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.
2. ESH is collecting data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market.
3. ESH is reviewing data about RN IIs and is reviewing options at developing an In-Band Adjustment for retention.
4. The part time hourly pool of RN IIs has been enlarged from 14 and now stands at 18 FTEs.
5. RNs who retired from ESH are actively being recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to retiree homes.
6. RNs who resigned from ESH are being recruited to return.
7. A revised brochure is being presented to mail to schools of nursing in Virginia to recruit senior nursing students to summer interns at the facility in 2002.
8. LPN vacancies were placed in continuous recruit.
9. The Educational Assistance Committee has approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients. The DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a daylong special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment - *Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42*

vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is ***ACTIVE.***

6 Month Status Report: 07/01/02

The Human Resource Department Central Office, has prepared a notebook of studies and an update of activities to enhance recruitment of nurses at ESH.

1. An In-Band Adjustment for Retention for 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.

2. ESH collected data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market. The new hiring range was not approved for use due to fiscal constraints.

3. ESH is reviewing data about RN IIs and wants to develop an In-Band Adjustment for retention.

4. The part time hourly pool of RN IIs has been enlarged and now stands at 18 FTEs. The hourly pool of LPNs has been expanded and now stands at 7.5 FTEs.

5. RNs who retired from ESH are actively recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to their homes. Two ESH retirees have returned as part-time hourly RNs.

6. RNs who resigned from ESH are being recruited to return with some success, i.e. re-employed four returning RNs

7. A revised brochure was mailed to schools of nursing in Virginia to recruit senior nursing students to work at ESH in the summer of 2002.

8. LPNs were placed in continuous recruit in the State Employment system.

9. The Educational Assistance Committee approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

10. Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients.

11. A referral bonus program has been instituted for RNs, LPNs and DSA IIs. Though available, no bonuses have been awarded to eligible employees for recruiting and referring new nursing staff.

EASTERN STATE HOSPITAL
UNANNOUNCED SNAPSHOT INSPECTION
JULY 9-10, 2001
OIG REPORT # 46-01

Finding 2.2: The facility is considering opening a transitional living program, to be housed in Building 28.

Recommendation: Facility administration must review this plan carefully with the Central Office prior to implementing to determine the legalities, outcome goals and regulatory requirements.

DMHMRSAS Response: Concur. Careful and thoughtful consideration continues to be given to the planned development of the transitional living program in Building 28, which has not be established at this time. The hospital is developing a proposal to be forwarded to the Central Office and the Assistant Commissioner for Facility Management where ramifications for the implementation of such a program will be considered. Any such program must comply with the programmatic curriculum provided within the concept of the Core Services Taxonomy approved by the State Board.

6 Month Status Report: 01/01/02
ESH continues interest in exploring the possibility of establishing a transitional living unit, which they see as a natural expansion of their psychosocial rehabilitation program. They recognize concerns relevant to the Olmstead decision, but believe there are patients who would benefit from a transitional program increasing their success in community placement. The General Assembly decision regarding capital funding for renovating buildings for use by their geriatric service will determine the need and use of Building 28. No decision has been made by Central Office at this time regarding the transitional living program.

OIG Comment – *Since no decision has been made by the Central Office regarding the feasibility of establishing a transitional living program, this finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
The General Assembly approved capital funding to renovate Buildings 28, 29 and 30 for geriatric patients. Although ESH may have a continued interest in establishing a transitional living unit, the use of these vacant buildings eliminates a viable location at ESH.

Finding 3.1: The facility ensures that there are adequate numbers of staff present on each of the units.

Recommendation: Maintain staffing levels for effective patient care.

DMHMRSAS Response: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities. During this 2001-2002 academic year, Eastern State Hospital is participating in the SHARPE (named in honor of Bob and Jane Sharpe, who have given funding to the College of William and Mary to support W&M students in working as volunteers to address compelling community needs and public issues enabling students to learn more about themselves, their world, and about the vital importance of using their skills, creativity and knowledge in an overall service to society) Community Partnership Program developed by the College of William and Mary, that is utilizing the Department of Economic to study the nationwide nursing shortage, specifically as it relates to the shortage of Registered Nurses. The goal is to develop additional strategies that include intangible issues such as job satisfaction, dignity and respect in the workplace, and actions that can be taken to improve untoward situations that exist. The possible provision of employer-sponsored childcare for employees is also under continuing study. The hospital also held Nursing Services Open Houses to attract qualified applicants.

6 Month Status Report: 01/01/02

A regular financial bonus each pay period was developed and approved at ESH for nursing staff that are willing to sign up for this voluntary overtime. It is awaiting approval in Central Office. A second bonus payment was developed for nursing staff that accumulated no unscheduled absences during each pay period. This is also awaiting approval in Central Office. No sign on bonus has been developed to improve recruitment opportunities due to fiscal constraints. The additional incentive, which was developed and approved, was a new hiring range for the RN I positions.

The hospital held Nursing Services Open Houses on 12/02/00, 03/24/01 and 08/25/01 to attract qualified applicants. The December Open House resulted in the hiring of 3 RNs and 3LPNs. In March, 5 LPNs were recruited and hired. The August Open House netted 1 RN and 4 LPNs.

The students from William & Mary College, who are participants of the SHARPE Community Partnership Program, have conducted the survey regarding the Nursing shortage. The data process has been completed, and the students are scheduled to work on a data analysis of this project during the Spring 2002 semester. It is anticipated that the entire project will be completed by May 2002. This possible provision of employer-sponsored childcare for employees is still being discussed at the facility as an incentive.

OIG Comment – *Interviews and a review of staffing reports demonstrated that the facility uses a variety of methods to ensure that the numerical staff to patient ratios are met. This is accomplished through the use of overtime, part-time positions and contract employees. Nursing staff related that due to the acuity of the patients that minimum staffing ratios might not provide sufficient resources for the active treatment of patients. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and is successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. These methods have proven to be successful. The Overtime Bonus Program for nursing staff has been approved and implemented. There is insufficient data to determine whether the program will increase recruitment or retention of nursing staff. The Attendance and Unplanned Leave Program has also been approved and implemented. Again, data is insufficient at this time to determine results or effectiveness. The concept of providing childcare service is still being formulated. However, due to the geriatric center relocation plan, facility space is limited. The three major issues evidenced by the SHARPE Nursing Research Project were 1) the benefits, 2) inadequate staffing and 3) respect. The Facility Director met with the Nursing Director, Medical Director and Human Resource Director to plan intervention for the identified issues. The successful intervention included regular advertisement in the newspaper and meetings with staff who have identified issues related to respect.

Finding 3.2: Staffing shortage is critical for nursing.

Recommendation 3.2 A: There should be a review of current policies and practices for managing overtime to assure equity among staff.

Recommendation 3.2 B: Any new practices should be done with formalized staff input.

DMHMRSAS Response 3.2 A: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities.

6 Month Status Report: 01/01/02
A regular financial bonus each pay period was developed and approved at Eastern State Hospital for nursing staff that are willing to sign up for voluntary overtime as well as a second bonus payment for nursing staff that accumulate no unscheduled absences during each pay period. This has been forwarded to Central Office for approval. There were no sign on bonus developed to improve recruitment

opportunities at present. The additional incentive, which was developed and approved, was a new hiring range for RN staff.

As an effort to work on the Nursing shortage statewide the DMHMRSAS Central Office is addressing work-force needs through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. The committee met on December 14, 2001 and sponsored a daylong special meeting, Charting the Course, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the sate Secretary of Health and Human Services.

OIG Comment - *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

Mandatory overtime is utilized as a last option. However, patient and staff safety is the facility's top priority. With an increase in census, efforts were minimized to eliminate mandatory overtime. Staffing needs of units are carefully evaluated to reduce mandatory overtime. The agency has experienced some success with recruitment. The state salaries are not competitive with the private sector, especially with limited funds for annual pay increases. The Nurse Staffing Committee meeting format was changed. Each program's Nurse Manager meets with the nursing staff assigned to the program to problem solve the staffing issues related to coverage. This method allows more autonomy for the Nurse Managers to problem solve the staff shortages utilizing input from the staff involved. (An example of this is, the staff in the admission's program agreeing to pilot the Baylor Plan.) The psychosocial program does alternative scheduling to accommodate staff needs and providing nursing coverage for the units. (An example of this is, allowing staff to work weekends and have other days off during the week.) These are examples of meeting the staffs' needs as well as meeting the nursing coverage for the unit, resulting in a "win", "win" situation.

DMHMRSAS Response 3.2 B: All new recommendations and ideas have been developed through the utilization of a formalized Nurse Staffing Committee, consisting of key management and line staff that have both the knowledge of current conditions and the ability to effect significant and successful change.

6 Month Status Report: 01/01/02

A formalized Nurse Staffing Committee reviews recommendations and ideas to effect significant and successful change. The Committee is examining the impact of the work environment on retention and is promoting a more positive image of Nursing Services throughout the facility. The Committee is also addressing other work related variables including work conditions, workload, and scheduling flexibility. Exit interviews are being reviewed to identify major factors of employee dissatisfaction.

OIG Comment - *Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

Nurse staffing committee meetings have been conducted within the buildings showing the highest use of mandatory overtime. Additional improvement is being made. This involves more evenly distributing staff across the shifts, and increased utilization of 12 and 16-hour shifts, where preferred. In addition to this, other alternative strategies are being considered, i.e. some staff prefers working more weekends than weekdays. The staff morale is currently of high priority for nurse management, with feedback from the clinical nursing staff. Where possible, interventions for corrections are being put in place. Mandatory overtime is currently under consideration by the American Nurse's Association.

ESH has expanded Internet posting of jobs.

The Admission's Unit will pilot the Baylor Plan for one (1) year and then evaluate the use of this plan. **The Baylor Plan** provides Eastern State Hospital with the ability to offer a scheduling option to attract and retain Registered Nurses to work weekends. All Registered Nurse II positions are designated to be used for the Baylor Plan. Registered Nurses (RNIIs) on the Baylor Plan will work three (3) 12-hour shifts over their scheduled weekend – Friday, Saturday, Sunday or Saturday, Sunday, Monday. For the 36 hours worked they will be paid for 40 hours and receive full state benefits.

Finding 1.1: Overall the physical environment of the Hancock Center was clean and comfortable, with evidence that effort has been made to decrease the institutional appearance.

Recommendation: Continue to promote efforts that result in softening and personalization of this harsh institutional setting.

DMHMRSAS Response: Eastern State Hospital will continue its ongoing efforts to personalize and promote a home-like environment. Purchasing, in collaboration with Clinical Leadership in Hancock Geriatric Treatment Center, continues by shopping catalogs for safe and appropriate accessories and decorations for the Geriatric clients.

6 Month Status Report: 07/01/02
Eastern State Hospital continues to enhance the therapeutic environment for geriatric patients. (Renovations to Building 28, 29, & 30 along with planned construction of a new geriatric activity building (Building 31), and the subsequent move of all patients from the Hancock Center must be considered when planning additional changes within the existing buildings in Hancock.) Requirements for the renovated facilities are currently being identified and consolidated for a funding request to the 2003 session of the Virginia General Assembly that will represent the balance of dollars that will be necessary to complete the geriatric relocation project.

Finding 2.1: The GAP (Geri-Active Program) is designed to meet the active treatment needs of the higher functioning geriatric patient.

Recommendation: The GAP program offers a variety of active treatment options for the minority of higher functioning geriatric patients. Administrative and clinical leaders must seriously re-evaluate the mission and model for active treatment for the remaining geriatric population at ESH.

DMHMRSAS Response: ESH HGTC's Interdisciplinary treatment teams will continue to assess patients' needs and functional level and develop specific treatment and care plans to address those needs and limitations. Additionally, monthly the GAP subcommittee will review current schedules, program descriptions, staff assignments, and patient participation data and make recommendations to HGTC Clinical Leadership to enhance patient interventions for all functional levels, to provide clarification to the Inspector General. GAP is the overall description of scheduled groups and activities for patients in geriatric services. IGAP is the "step-up" program for the 40-50 higher functioning patients in geriatrics.

6 Month Status Report: 07/01/02
Eastern State Hospital HGTC Clinical Leadership Team continues to emphasize to treatment teams and each discipline the need to ensure that all patients are receiving active treatment based upon their needs and functional levels. The GAP Subcommittee is charged with reviewing program schedules, patient related data, and staff assignments for optimum use of resources.

Finding 2.2: Active therapeutic treatment options for lower functioning geriatric patients were minimal.

Recommendation: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatrics Treatment Center and all discipline supervisors will ensure groups/activities are conducted according to the schedule, according to group objectives, and content as outlined in the specific program descriptions and based upon the patients' interests and needs. Monitoring of the process will be accomplished daily utilizing the Visual Patient Contact Application (VPCA). This is a computerized system, which measures time spent with patients related to structured treatment activities. Supervisors will review patient participation to identify patients who may be underserved through the group process and who may benefit from more individualized attention. The GAP subcommittee will oversee and coordinate these efforts through its monthly meetings and findings will be reported to clinical leadership.

6 Month Status Report: 07/01/02
Eastern State Hospital HGTC Clinical Leadership Team has developed a more comprehensive and complete review of active treatment activities with and for the lower functioning geriatric patients. Staff education is planned to increase staff's knowledge and ability to articulate the daily active treatment that is occurring.

Finding 2.3: Late afternoon and early evening activities in Building 34 were not taking place as scheduled.

Recommendation: A review of the active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatric Treatment Center will assess afternoon and evening patient care needs and routines. They will communicate the schedule and expectations to all staff. The treatment teams will identify relevant active treatment interventions for individual patients to improve function, or reduce loss of function. The estimated completion date for assessing the needs and identifying the interventions is May 31, 2002. Current scheduled GAP groups end by 3:00 p.m. Evening programming, when scheduled, begins at 6:00 p.m.

6 Month Status Report: 07/01/02
Ongoing the facility does a complete review of the overall program and patients' daily schedule by the Clinical Leadership Team and GAP Subcommittee. This ensures that programs are occurring as scheduled and not conflict with individual patient care related activities. A Master Schedule revision is currently being developed for implementation in July 2002.

Finding 2.4: Records reviewed reflected limited documentation linking treatment needs to discharge readiness and the justification for continued hospitalization.

Recommendation: Promote better utilization of the clinical talent participating in the treatment planning conferences. Improve concentration by the teams on issues related to preparation of patients for discharge, as evidenced in the records.

DMHMRSAS Response: To promote improved utilization of the clinical staff's participation in treatment planning conferences, the HGTC program is implementing a computerized treatment planning system (Vista Care), which will reduce the overemphasis on the completion of forms. Vista Care requires the development of plans for particular patients based on triggered areas of the MDS (minimum data sets). This would be beneficial to both higher and lower functioning patient groups. In addition, the recently implemented use of the "Needs upon Discharge" form will not only add to the consolidation and streamlining of paperwork, but will better focus the team's efforts on resolving discharge barriers in a more expedited fashion.

6 Month Status Report: 07/01/02
The program implemented was incorrectly identified as Vista Care when in fact, it is the VistaKeane System. As of June 13, 2002 the percentages of care plans entered into the VistaKeane System are: Building 4: 100% completed; Building 32: 95% completed; Building 34: 25% completed; Building 36: 100% completed Average HGTC/Medical Services: 80% completed {164 out of 206 completed} Building 32 will be 100% complete by June 28th. Building 34 will maintain its 2 plans per week implementation process. It is envisioned that by training more RNs (8) in computerized care plans, the efforts of MIS (new hardware and improved computer lines throughout HGTC) and patient transfers from B-32 with computerized care plans, all patient care plans will be computerized in HGTC. Estimated completion date for computerization of all plans is October 1, 2002.

Finding 3.1: Staffing shortages are critical for nursing services in the Hancock Center.

Recommendation: Administrative and clinical leaders must seriously re-evaluate the mission and model for the goals of serving the geriatric population. Increase staffing levels as needed for active, effective patient treatment rather than basic patient care if this is determined to be the treatment goal for the Hancock Center.

DMHMRSAS Response: The assessment of the recruitment and retention of nursing staff is ongoing. Recruitment of nursing staff in Hancock Geriatric Treatment Center (HGTC) is difficult, in part, due to the required physical work involved with geriatric population. However, the staff that work in this area desire to do so. Through contract nursing staff are utilized, few of them desire to work with the geriatric patients. The above conditions often contribute to the need for mandatory overtime. There is a system in place for this and has been reviewed with the nursing staff. There is a mandatory overtime list, however, voluntary overtime is utilized first as

well as hourly and contract staff. When these options are not possible, mandatory overtime is required. Once the nurse works overtime, his/her name goes to the bottom of the list.

Despite the above issues, the Nursing Department continues to recruit and retain nursing staff with strong support from our Human Resources Department. Since December 2001, we have hired eight (8) DSA's and one (1) LPN for duty in geriatrics. Additionally, two (2) Registered Nurses have been offered positions. Recruitment and retention is ongoing at ESH.

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and has been successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. This method continues to be utilized with some success.

HIRAM W. DAVIS MEDICAL CENTER
SNAPSHOT INSPECTION
JULY 29, 2002
OIG REPORT #65-02

Finding 1.1: The facility was clean, comfortable and well maintained.

Recommendation: Continue with planned efforts to provide increased opportunities for stimuli to be available for all patients at the facility.

DMHMRSAS Response: One plan to increase opportunities for stimui, the Patient Pavilion has been completed and will be inaugurated with a Patient-Family Picnic September 25, 2002. The pavilion will increase opportunities for patients to be outside in a covered shelter. A workgroup has met twice to develop plans for using the pavilion.

To increase opportunities for increased stimuli inside the facility, the staff office space in the 3rd floor Therapeutic Recreation Room is being consolidated to increase patient use of the room. Nursing takes patients to this room when it is not in use by Recreation. This increases patient socialization and allows the patients increased time out of their rooms. To increase patient interaction and to normalize mealtimes, part of the room is being used for patient dining. This eliminates the need for patients eating in the hallway as they had previously done due to space limitations.

Other efforts to increase patient activities and mobilization include:

- Two volunteers who focus on reading to patients and assisting with patient transport to activities.
- A music group run by the Social Services Department supplements regularly scheduled Recreation groups.
- Rehabilitative Services and Nursing Service work cooperatively to find the most appropriate wheelchairs or other mobility aids for getting patients out of bed.

- Rehabilitative Services contacts the home facility of any new admission to have any custom wheelchairs transferred to HWDMC for the patient's continued use.
- Rehabilitative Services is works cooperatively with the SVTC Wheelchair Evaluation Team and Wheelchair Shop to ensure that patients have the most appropriate mobility aid.

Finding 2.1: Staffing patterns were consistent with facility staffing expectation despite only one RN providing coverage for both units on the 3rd Floor.

Recommendation: Review current practice of staffing RNs to assure that adequate coverage is maintained for these complicated patients.

DMHMRSAS Response: Four Registered Nurses have been employed since this survey was conducted. All are currently in the process of completing clinical orientation. These additional Registered Nurses will assist in alleviating the issue of one RN covering for both 3rd floor units. One RN may be used to provide coverage for both units on the 3rd floor in the following situations:

5. The patient acuity level is low.
6. There are enough Licensed Practical Nurses on duty (minimum of 8-9 LPN's) to support the Registered Nurse.
7. The RN assignment frees her to circulate and make frequent rounds.
8. The Nursing Supervisor on duty (on-call) gives approval, and makes the determination that one RN will not jeopardize the patients.

Finding 2.2: Use of mandatory overtime has been very limited during the past six months.

Recommendation: Continue to discourage the use of mandatory overtime as a remedy for staffing shortages.

DMHMRSAS Response: The facility will continue to monitor, and analyze the mandatory overtime data collected monthly; continue to hire Float Pool staff (P-14), as supplemental staffing; use patient acuity as the baseline for staffing decisions rather than using the mandatory overtime to meet the numbers; continue to enforce the Nursing staffing adjustment policy, wherein employee time schedules are posted for a six -week period with requests for planned absences after posting is granted only if the employee requesting off switches days off with another staff member. This maintains appropriate numbers of staff to accommodate any unplanned absences, thereby reducing mandatory overtime use.

Finding 2.3: HWDMC coordinates internally and with surrounding facilities to offer a variety of supports to staff seeking to pursue advanced training.

Recommendation: Continue to fund and facilitate opportunities for staff to receive advanced career training.

DMHMRSAS Response: HWDMC encourages employees to attend school for upward mobility. Funding for school is based on the criteria set forth in the HWDMC Employee Educational Assistance Instructions. Currently, thirteen nursing staff are pursuing advanced nursing careers. Two Licensed Practical Nurse are enrolled in Registered Nurse Programs, ten Certified Nurse Aides are enrolled in Licensed Practical Nurse programs, and one RN is enrolled

in a Bachelor of Science in Nursing program. Four other non-nursing staff are pursuing advanced careers in fields such as computer science, business management, healthcare and social work. In addition, one of the nursing staff successfully completed the transitional LPN to RN program in 2000, utilizing the Educational Leave and the educational assistance provided by HWDMC. The work schedules of the employees who are enrolled in advanced career classes are accommodated based on their class schedule, which results in an approved special shift schedule. The employees enrolled in school are also exempted from the mandatory overtime during their class days. Although these special work schedule accommodations are provided to these employees, appropriate coverage for patient care is still the main priority.

The Petersburg campus (HWDMC, SVTC and CSH) has been pursuing Workforce Development initiatives. SVTC is leading these initiatives that include the School –at – Work Program, and community college classes on campus. Governor Warner has officially designated the DMHMRSAS Petersburg Campus as the "Workforce Development" demonstration and pilot site. Classes will include RN, LPN, or any other college courses including computer technology, HVAC, and childcare. Twenty-nine employees took the John Tyler Community College admissions test last August 2002. There are plans to apply for several Grant programs for funding. A meeting was held on September 20th with a representative of the Capital Compassion Fund.

Finding 2.4: HWDMC has experienced a change in psychiatric consultant.

Recommendation: Continue to support access to psychiatrist for those patients in need at HWDMC.

DMHMRSAS Response: Until recently, psychiatric consultations for those patients permanently assigned to HWDMC are provided by locum tenens physicians who had experience managing patients similar to our patient population. Contract psychiatrists from the Virginia Commonwealth University, Medical College of Virginia Section (MCV) are now used. There are many advantages to further developing relationships with MCV. Instead of one locum tenens physician, there are several board certified psychiatrists involved with patients in an academic setting and full time coverage is available if questions arise when the contract psychiatrist is not physically present at HWDMC. The academic setting also provides current and developing medical knowledge.

Patients transferred from Central State Hospital to HWDMC on special hospitalization status for medical problems, continue to be followed by their attending psychiatrists.

Finding 3.1: Active treatment is challenging for this complex and medically fragile population.

Recommendation: Continue efforts at assuring that each person has the opportunity to engage in appropriate levels of activity in order to maintain and/or improve their current level of functioning.

DMHMRSAS Response: The Restorative Team continues to guide planning and implementing patient restorative programs. Policies and procedures for a Bowel and Bladder program and Splinting and Positioning program have been developed including staff training and Team review. Future programs include Range of Motion and Dining.

The Therapeutic Recreation Department has started using a new Die-Cut machine with patients. This machine enables patients to create many paper craft projects.

With more patients getting out of bed in specialized wheelchairs, more patients are able to go on rides or travel to outings in the facility's wheelchair lift van.

Social Services, Therapeutic Recreation, and Occupational Therapy are exploring ways to implement an Assistive Technology Program for patients. HWDMC patients may be transported to the SVTC Technology Lab when not in use by SVTC patients.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO SNAPSHOT INSPECTION
NOVEMBER 9, 2001
OIG REPORT #49-01

Finding 3.2: Discharge planning continues to be a significant challenge for this facility.

Recommendation: Continue to strive for successful linkages for all patients at the time of discharge.

DMHMRSAS Response: DMHMRSAS concurs. The discharge planning process at NVMHI has been in place for 14 months since revision in November 2000. Performance monitoring continues to show sustained improvement, scoring above threshold for the past 5 monitoring periods. Monitoring of the discharge planning process continues to show strong integration between the CSBs and the treatment teams. CSB Aftercare workers continue to demonstrate a consistent presence at CTPs, TPRs, weekly meetings with patients, and family meetings.

In late December 2001, an educational program on "Discharge Protocols for CSBs and State Mental Health Facilities" was presented by DMHMRSAS staff. New Departmental Discharge Protocols were reviewed to ensure standardization of the process across facilities. Two sessions were conducted and 59 staff were in attendance, including: psychiatrists; psychologists; nurses; social workers; CSB Aftercare workers; utilization management staff; and the patient advocate.

6 Month Status Report: 07/01/02
NVMHI has developed and published an updated discharge planning policy to implement the statewide "Discharge Protocols for Community Services Boards and State Mental Health Facilities". The CSBs are committed to successfully implementing both the state performance contract and the "Discharge Protocols for Community Services Boards and State Mental Health Facilities". Both of these documents directly address the need for consistent direction and coordination of those activities that result in the successful linkages for all patients at the time of discharge. The results of the newly developed NVMHI Discharge Planning Quality Monitor have exceeded the 90% threshold during the first two months of monitoring. This data demonstrates that there continues to be successful linkages for all patients at the time of discharge, as evidenced by the strong integration between the CSBs and the

NVMHI treatment teams.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO SNAPSHOT INSPECTION
JULY 16-17, 2002

Finding 1.1: Overall, the facility was generally clean, comfortable and well maintained.

Recommendation: Continue to maintain the facility and maximize efficient use of limited space.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates the Inspector General's recognition of NVMHI's efforts. NVMHI continues to maintain the treatment environment with both preventive and corrective housekeeping and engineering programs. Regular rounds are conducted to monitor the environment, and work orders are promptly submitted for any required repairs.

Finding 2.1: Staffing patterns for nursing services were adequate.

Recommendation: Continue to provide adequate staffing patterns.

DMHMRSAS Response: DMHMRSAS concurs. Adequate staffing patterns will continue to be provided.

Finding 2.2: Seven of eight staff members interviewed did not understand reporting structure of abuse and neglect.

Recommendation: Retrain all staff regarding the correct reporting process and procedures as outlined in this policy. Review current mechanism within the facility through which allegations are reported to assure that all allegations are properly handled and addressed.

DMHMRSAS Response: DMHMRSAS concurs. New Employee Orientation and Annual Update Training currently include a Human Rights video explaining the Reporting and Investigation of Abuse, Neglect and Exploitation. Effective immediately, the Training Coordinator will assess via verbal interaction, individual understanding of the procedure involved in the different processes as part of the training program. The training Department also will provide a presentation based on the facility policy, *Reporting and Investigating Abuse and Neglect of Patients*, as a hospital wide in-service to staff. This presentation will be available for staff meetings and as an on-line training module. In addition, nursing leadership will regularly test staff competencies on the reporting process through interviews and role-playing a variety of scenarios. Nursing Unit Managers will re-test staff knowledge in three (3) months via verbal reviews and role play situations on each nursing units.

The Nursing Managers will discuss the abuse and neglect reporting structure within the nursing unit and department-wide meetings in order to better understand the sources of confusion and/or barriers. Using the information gained, strategies will be developed to assure compliance with the direct reporting requirement. These strategies will encompass ways to provide direct report

as well as to notify the supervisor that coverage must provided for the employee leaving the unit as well as allow supervisor opportunity to take immediate action to protect the patient.

Finding 2.3: NVMHI offers a variety of supports to staff seeking to pursue advanced training.

Recommendation: Continue to provide a variety of supports for staff to advance. Make sure that supports and training opportunities are made known to staff.

DMHMRSAS Response: DMHMRSAS concurs. Scheduling adjustments to support staff participation in training will continue to be provided. Financial support will be consistent with facility budget and guidance from Central Office.

Finding 3.1: NVMHI continues to monitor and revise the active treatment program in response to patient functioning, experience and individual treatment goals.

Recommendation: Continue to offer active treatment that is designed to meet individualized needs. Review methods for incorporating the model of active treatment noted on the mall on the admissions unit.

DMHMRSAS Response: DMHMRSAS concurs. All discipline directors will discuss barriers to increased individual and group activities to support newly admitted patients to achieve treatment goals. Based on findings, the PSR Director and the Director of Psychiatry will provide leadership for unit based program development. The Clinical Leadership Group will discuss paradigms for recovery based programs on all units.

Since the treatment mall integrates individuals into groups that are related to their specific treatment needs, the number of F unit patients attending treatment mall programming varies from hour to hour depending on the patients' needs and the groups being offered that hour.

Therapeutic activities are scheduled on F unit throughout each afternoon. Some of these activities include: aftercare meetings with the community liaison, psychotherapy groups, leisure education groups, substance abuse groups, and music therapy. In addition, the Performance Improvement Team (see Response 3.2) is exploring more efficient ways of capturing other elements of active treatment provided in addition to groups.

Nonetheless, the clinical leadership acknowledges the unique challenge of providing active treatment and engaging patients on an admissions unit where the average length of stay is 14 days. The need to develop a different programming model is under consideration. This issue will added to the charter of the Performance Improvement Team as noted in Response 3.2.

Finding 3.2: Tracking of active treatment participation was identified as inconsistent.

Recommendation: The OIG supports the convening of the performance improvement team to review current status of the active treatment program, including patient participation, strategies for actively engaging persons in their recovery process and effective, consistent documentation of participation both individually and collectively. NVMHI is encouraged to dialogue with Central State Hospital and Southwestern Virginia Mental Health Institute on strategies engaged by the facilities in these areas.

DMHMRSAS Response: DMHMRSAS concurs. A Performance Improvement Team focused on patient attendance at programming began work in June 2002. One sub-group is working specifically on putting mechanisms into place that will ensure consistent tracking of all active treatment, including off-site programming (such as attendance at community PSR programs) and evening and weekend activities. A second sub-group of the Performance Improvement Team is working on identifying strategies that treatment teams can utilize to encourage more active participation by patients in their treatment. Additionally, the PSR Director has been in direct contact over the last month with the PSR Directors at CSH, ESH and WSH to investigate successful strategies utilized at those facilities. After review of those strategies by the NVMHI Performance Improvement Team, one or more of these strategies will be pilot-tested with the goal of determining the most effective strategy(ies) appropriate to the facility's population.

Finding 4.1: Record reviews reflected that the overall treatment provided patients, including the treatment and discharge planning process, was individualized; linking the initial assessments, treatment planning and discharge needs to identified barriers.

Recommendation: Continue to document the clinical process of linking assessments to treatment and discharge.

DMHMRSAS Response: DMHMRSAS concurs. NVMHI will continue to monitor the documentation of the clinical process linking assessments to treatment and discharge to ensure that gains are maintained in this area.

NORTHERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION
SEPTEMBER 9-11, 2001
OIG REPORT # 48-01

Finding 1.3: The Facility Risk Manager also functions as the Quality Assurance Director, and serves as the facility Abuse and Neglect Investigator.

Recommendation: The facility needs to review with the Central Office the nature of these functions with serious consideration given to the separation of each of these three tasks to assure that the protection of the residents are foremost.

DMHMRSAS Response: It is anticipated that in the next several months, DMHMRSAS will be centralizing all abuse/neglect positions to assure that Abuse/Neglect investigations are not undertaken by persons serving multiple and/or conflicting roles in the facility. They will serve and be trained in the singular function of Abuse/Neglect Investigations.

At present, two different NVTC staff are responsible for the risk management function and the quality assurance function. However, one of these persons has supervisory responsibility over both functions. The Director of NVTC will review the supervisory function performed by the Risk Manager relative to the Quality Assurance staff to determine if this role is a conflict of interest. A decision will be made by December 31, 2001 and forwarded to the Central Office for review.

6 Month Status Report: 01/01/02

DMHMRSAS will be centralizing all abuse/neglect investigations to assure that persons serving multiple and/or conflicting roles do not undertake such investigations. NVTC continues to maintain a Risk Manager with supervisory authority over the Quality Assurance manager. The Risk Manager reports directly to the NVTC Director. The NVTC Director reviewed the supervisory relationship of the Risk Manager relative to the Quality Assurance manager and determined that Risk Management is a key part of the organizations dedication to improved performance, safety, efficiency and productivity. Although the NVTC risk manager is supervising the functions of the quality assurance manager the two staff work in tandem to integrate quality control management and quality assurance. The two positions work closely to assess the various types of risks that exist across the center and to identify strategic control and improvement plans. The quality assurance manager reports on the quality of care to the clients, the systems to improve performance and the protections in place to protect individuals. The Director of NVTC requires the relationship between the two positions to continue in the complimentary fashion with which they have existed.

OIG Response**: Interviews demonstrated that the facility continues to use the risk manager in the role of the primary abuse investigator. The facility provided a copy draft DI 201, which outlines proposed changes in the investigative process. This finding remains **ACTIVE.

6 Month Status Report: 07/01/02

Until such time as the DMHMRSAS proposed centralization of all abuse/neglect investigations occurs, the NVTC Risk Manager continues to function as the primary abuse investigator. However, during any Abuse/Neglect Investigation, the Risk Manager is directly accountable to the Central Office Manager of Abuse/Neglect Investigations during the entire investigation process, and not to facility management. The Central Office Abuse/Neglect Investigation Manager supervises the process until a thorough and complete investigation is concluded.

In recent months, due to staff turnover, NVTC has been reduced to two certified investigators at the center. To address the need for additional investigators, NVTC will select candidates from existing staff to obtain the next statewide Investigation Certification Training, which is planned for October of 2002. NVTC will enroll at least one staff member to become a certified investigator; and additional staff may attend depending on the availability of openings at the training. As more NVTC staff are certified to investigate allegations of abuse/neglect, the Risk Manager can delegate the investigations, thereby reducing the dual role.

***OIG Comment – (January 2003)** Interviews with administrative staff revealed that the Risk Manager at NVTC continues to also function in the role of primary abuse and neglect investigator. This is in conflict with the plan of correction submitted by the Central Office in a report at another facility with a similar finding in which it was stated that the Department anticipated that by August 2001, a statewide plan would be developed to assure that each facility*

has a designated investigator whose role did not conflict with an institutional operations role.

NVTC has four staff members excluding the Risk Manager, who have completed the abuse and neglect investigator training and could assure that these individuals are assigned to complete this function until this issue is resolved. Until action has been completed by DMHMRSAS, this finding remains ***ACTIVE.***

6 Month Status Report: 03/01/03
NVTC has four trained DMHMRSAS Abuse and Neglect Investigators in addition to the Risk Manager. As of 10/1/02, NVTC elected that the Risk Manager shall no longer conduct abuse/neglect investigations. All investigations shall be performed by one of the other trained investigators. The last investigation conducted by the NVTC Risk Manager was completed on 9/24/02. The Risk Manager will continue to provide oversight and monitoring of investigations as part of his job duties to assure adherence to policy and procedures and timely follow-up of recommendations.

PIEDMONT GERIATRIC HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION
JULY 14, 2000
OIG REPORT #28-00

Finding 3.1: There is inadequate RN coverage for this facility on weekends, during evening and night shifts as well as weekdays on night shift.

Recommendation: Facility management and Central Office develop a plan to correct this deficiency in RN staffing.

DMHMRSAS Response: Concur. Piedmont will continue its recruitment and Retention efforts of the RN staff. Current efforts include ongoing advertisement, sign-on bonuses, flextime, weekend/shift differentials, paid relocation expenses and continuing education/nursing scholarships. Piedmont will include the nursing staff in the development of a more fully developed Nursing Retention Plan. This plan proposing recommendations will be submitted to the Central Office by September 30, 2000.

6 Month Status Report: 7/1/01
There are three RNs on the evening shift on weekends as well as weekdays. One (1) RN is on the Admission Unit and two (2) supervisors to cover the remaining four shifts. On the night shift on the weekend there is one (1) RN on the Admission unit and one (1), sometimes two (2) supervisors to provide coverage for the other four units. PGH will work with the Director of Human Resources in Central Office to develop a budget plan to hire the additional RNs. To meet the DOJ requirements the facility will need 3 additional RNs with a ratio of 1:19 on the evening, weekend and night shift.

OIG Comment *- Interviews indicated that the facility does not have per unit RN coverage consistently during the non- day shifts. There is an RN supervisor available but LPN's attends to unit care. The knowledge base for making on-going assessments and clinical judgments for this*

vulnerable population often with multiple health-related issues is critical and requires at the least the expertise of a registered nurse. This finding is ***ACTIVE.***

6 Month Status Report: 01/01/02
The facility's current nursing staff has been deployed to cover the evening, night and weekend shift. (Please refer to the July 1, 2001 response) The Nursing Director continually works with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. And the facility will continue to downsize to meet DOJ staffing coverage.

OIG Comment- *Interviews with administrative staff indicated that the facility continues to function without an RN available on each unit on each shift. Efforts have been made by the facility to secure additional funding to hire the complement of nurses necessary to meet this requirement. This is a critical concern in addressing the medical needs of this complicated population. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
The Nursing Director continues to work with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. Also, Piedmont has continued to schedule a RN on each of the five units for the evening shift when RNs are available. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. PGH will continue efforts to enhance RN staffing on the night shift. It is hoped that the market adjustment plan for primary nurses being implemented will enhance recruitment and help with retention of nurses.

OIG COMMENTS: (February 2003) *Interviews conducted with administrative and direct care staff revealed that the facility continues to function without having an RN on each unit for each shift. The facility is attempting to deal with budget reductions without laying-off direct care staff. The Director of Nursing has reviewed current staffing configurations and adjusted staffing deployment in an effort to increase RN coverage during the evening and night shift. Supervisory positions have been assigned to unit nursing duties. Even with scheduling adjustments and unit consolidation, this facility continues to function with only two RNs assigned to four units during the night shift. The team conducted a tour of the units on all three shifts and staffing patterns were reported in OIG Report#75-03. It was noted during the tour that on 2 West during the night shift (the unit that houses the most medically and physically compromised patients) there were no RNs scheduled, only one LPN (there are normally two) and three HSCW (however, one was assigned to 1:1 duty) for the 33 patients. Several of the patients were described as needing frequent monitoring due to active medical concerns. The OIG has noted in previous reports that it is particularly important for the safety of these individuals to have an RN on the unit to conduct the level of assessment necessary to address and monitor the complex needs of this population.*

It was also noted in a record reviewed by the team that a community-based medical follow-up appointment was cancelled due to the staff shortage and rescheduling of this appointment was not noted. A member of the OIG team observed a patient fall and had to go locate staff in order for them to assist the person. There is clear evidence that attempts are being made to increase access to RN staffing, however because the minimal DOJ expectation for one nurse per shift per unit have not been met, this finding remains ***ACTIVE.***

Status Report: 03/01/03

Rotation of all RNs who have previously worked predominately day shift to night shift effective Feb./March schedule. (**2W and Ground Floor to start rotation when RN positions are filled and 2 positions were filled 3/10/03)**

Assigned shift supervisors (3) to night shift on 3W, Gr. Fl. and to the evening shift on 2W who will be providing direct care. (These shift supervisors provide relief coverage for the Night and Evening Coordinators.)

Assigned RNs from 2E (Consolidated Unit):

1 Unit Coordinator to Gr. Floor (provides direct care)
2 to Ground (rotating)
1 to 2 West (rotating)
2 to 1 West (1 West has the Admission Suite and JCAHO mandates 24hour RN coverage

RN recruiting is done continuously

1 new hire 3/10/03 for Gr. Floor
1 new hire 3/10/03 for 2 West
Awaiting acceptance to offer to applicant for night shift –2 West
Advertising for evening and night shift RNs

Recruitment and retention of RN's continues to be a facility priority as the shortage of RN's continues to grow nationally.

PIEDMONT GERIATRIC HOSPITAL

SNAPSHOT INSPECTION
MARCH 25, 2002
OIG REPORT # 58-02

Finding 2.1: Staffing patterns were minimally adequate.

Recommendation: Enhance staffing ratios so that there is more access to RN staff per patient.

DMHMRSAS Response: While PGH current staffing meets safety standards, the Department recognizes the need to have a full complement of nursing staff. In an effort to fill all nursing positions, PGH has maintained continuous recruitment for RNs and LPNs and continues to ensure that nurses now on-staff are deployed to best meet the needs of the patient population. To

facilitate access to RNs on-duty, radio communication is maintained with all patient care units. Piedmont continues to experience a relatively low staff turnover rate compared to the national average of health care facilities and other DMH facilities.

6 Month Status Report: 07/01/02
PGH continues to use continuous recruitment for RNs and LPNs and ensures that nurses now on-staff are deployed to best meet the needs of the patient population. On 5/31/02 an Open House for RNs and LPNs was held. From this effort, two RNs are applying for vacant positions. One of three LPNs assisted by PGH to attend RN School, has completed school, passed State Boards and will fill one of the vacant RN positions. The two others accepted employment elsewhere. Piedmont has developed a market adjustment plan in salaries of the RNCA (primary nurse) in an effort to retain present staff. To facilitate access to RNs on-duty, radio communication is maintained with all patient care units.

OIG Comment: (February 2003) Please refer to finding 2.2 for response.

Finding 2.2: Nursing coverage during the evening and night shifts does not provide for 1 RN per unit.

Recommendation: Continue to pursue the hiring of these positions for the well being of these often medically complicated and fragile patients.

DMHMRSAS Response: [Also refer to Response to Finding 2.1] PGH has continued to schedule a RN on each of the five units for the evening shift. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. PGH will continue efforts to enhance RN staffing on the night shift.

6 Month Status Report: 07/01/02
PGH has continued to schedule a RN on each of the five units for the evening shift, Monday through Friday to facilitate program implementation. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. There are one classified and 2 hourly RN vacancies on the night shift. PGH will continue efforts to enhance RN staffing on the night shift. It is hoped that the market adjustment plan being implemented will enhance recruitment and help with retention of nurses.

OIG COMMENTS: (February 2003) *Interviews conducted with administrative and direct care staff revealed that the facility continues to function without having an RN on each unit for each shift. The facility is attempting to deal with budget reductions without laying-off direct care staff. The Director of Nursing has reviewed current staffing configurations and adjusted staffing deployment in an effort to increase RN coverage during the evening and night shift. Supervisory positions have been assigned to unit nursing duties. Even with scheduling adjustments and unit consolidation, this facility continues to function with only two RNs assigned to four units during the night shift. The team conducted a tour of the units on all three shifts and staffing patterns were reported in OIG Report#75-03. It was noted during the tour that on 2 West during the night*

shift (the unit that houses the most medically and physically compromised patients) there were no RNs scheduled, only one LPN (there are normally two) and three HSCW (however, one was assigned to 1:1 duty) for the 33 patients. Several of the patients were described as needing frequent monitoring due to active medical concerns. The OIG has noted in previous reports that it is particularly important for the safety of these individuals to have an RN on the unit to conduct the level of assessment necessary to address and monitor the complex needs of this population.

It was also noted in a record reviewed by the team that a community-based medical follow-up appointment was cancelled due to the staff shortage and rescheduling of this appointment was not noted. A member of the OIG team observed a patient fall and had to go locate staff in order for them to assist the person. There is clear evidence that attempts are being made to increase access to RN staffing, however because the minimal DOJ expectation for one nurse per shift per unit have not been met, this finding remains ***ACTIVE.***

Status Report: 03/03

The following are being implemented to increase RN coverage on the evening and night shifts:

Rotation of all RNs who have previously worked predominately day shift to night shift effective Feb./March schedule. (**2W and Ground Floor to start rotation when RN positions are filled and 2 positions were filled 3/10/03)**

Assigned shift supervisors (3) to night shift on 3W, Gr. Fl. and to the evening shift on 2W who will be providing direct care. (These shift supervisors provide relief coverage for the Night and Evening Coordinators.)

Assigned RNs from 2E (Consolidated Unit):

1 Unit Coordinator to Gr. Floor (provides direct care)
2 to Ground (rotating)
1 to 2 West (rotating)
2 to 1 West (1 West has the Admission Suite and JCAHO mandates 24hour RN coverage

RN recruiting is done continuously

1 new hire 3/10/03 for Gr. Floor
1 new hire 3/10/03 for 2 West
Awaiting acceptance to offer to applicant for night shift –2 West
Advertising for evening and night shift RNs

Recruitment and retention of RN's continues to be a facility priority as the shortage of RN's continues to grow nationally.

Finding 3.2: Linkages between active treatment, barriers to discharge and the treatment planning process was evident in records reviewed.

Recommendation: Consider the active sharing of this process with other facilities serving segments of the geriatric population.

DMHMRSAS Response: The Department appreciates your recognition of staff efforts regarding discharge preparation. A new format for the Facility Directors meeting is being developed which, in the future, will enhance the sharing of exemplary practices between facilities. PGH is willing to share this information with other geriatric treatment units.

6 Month Status Report: 07/01/02
PGH will share efforts regarding active treatment, barriers to discharge and the treatment planning process with other geriatric treatment units as the opportunity arises at future Facility Director's meetings. .

OIG Comment: (February 2003) *There was evidence in the ten records reviewed that PGH continues to demonstrate linkages between the initial and on-going assessments of the patients with the formation of active problems and identified barriers to discharge with the prescribed interventions and active programming. Team involvement was documented. As the facility is currently changing its system for delivery of active treatment with its development of the SMILE program, this finding will remain* ***ACTIVE.***

Status Report: 03/03
In addition to the newly implemented SMILE (Skills Mastery for Independent Living Enhancement) program, which is a consolidation of the previous psychosocial rehab programs, each unit has group treatment programs provided by Nursing, Social Work and Psychology. During the past 60 days the Director of Rehabilitative Services has been working closely with the Nursing Department by having Rehabilitation Staff work cooperatively with the Clinical Nurse Specialists and Unit Coordinators on the other Units to plan and continue to schedule appropriate treatment modalities, activities, and events for the patients. The Senior Recreation Center has been added to the Program Schedule for each Unit. The Occupational Therapist (2) will also plan and conduct psychosocial groups (Sensory Stimulation, ADL Training and Horticulture) in addition to assisting the CNS's with Feeding Programs. The Clinical Leadership Team does quarterly review of Active Treatment hours and adjustments are made to meet any deficits. (A copy of the report on active treatment hours is available for the date of the follow-up visit on March 3, which confirms the OIG observations.) Individual Treatment Plans are developed by Multi-disciplinary Treatment Teams and implemented with consideration of the patients' level of physical and cognitive functioning.

NOTE: As indicated above, PGH has recently implemented a new Senior Recreation Center where patients can get off the unit and attend various programs. The Center modalities are available one day a week to patients from all units. In addition, forensic patients (housed on 3-West) attend every day. The program is designed to allow patients the freedom of choice in recreational, diversional / music and special events. The Center provides the opportunity for patients to interact with others outside of their present environment, similar to centers in the community. A Sensory Stimulation Room is being developed with sensory lights and a large aquarium, which should be completed by the end of March. There will be four rooms set-up with activities scheduled and carried out in each of the rooms daily, based on patient's level of functioning. Pet Therapy, Gardening, and outside Entertainment Groups will be forthcoming. Unit based Program staff also have the opportunity to plan or request their own special activities or events for their patients on their scheduled days at the Center.

PIEDMONT GERIATRIC HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION
FEBRUARY 4-5, 2003
OIG REPORT #75-03

Finding 1.1: Progress has been made toward the goal of one RN per unit per shift.

Recommendation: Pursue the plans for a minimum of one RN per unit per shift. The OIG requests updates regarding the progress in addressing this staffing issue.

DMHMRSAS Response:

The following are being implemented to increase RN coverage on the evening and night shifts:

Rotation of all RNs who have previously worked predominately day shift to night shift effective Feb./March schedule. (**2W and Ground Floor to start rotation when RN positions are filled and 2 positions were filled 3/10/03)**

Assigned shift supervisors (3) to night shift on 3W, Gr. Fl. and to the evening shift on 2W who will be providing direct care. (These shift supervisors provide relief coverage for the Night and Evening Coordinators.)

Assigned RNs from 2E (Consolidated Unit):

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RN recruiting is done continuously

1 new hire 3/10/03 for Gr. Floor
1 new hire 3/10/03 for 2 West

Awaiting acceptance to offer to applicant for night shift –2 West
Advertising for evening and night shift RNs

Recruitment and retention of RN's continues to be a facility priority as the shortage of RN's continues to grow nationally.

Finding 2.1: PGH has implemented a new program for patients on 1 West. Limited therapeutic programming was available for the patients on the other three units.

Recommendation: PGH needs to assure that programming is provided for all patients depending upon their level of functioning. Scheduled actives were reportedly not occurring due to staffing shortages. This needs to be reviewed.
DMHMRSAS Response:

For clarification purposes, it needs to be noted; the hospital has reviewed its Psychosocial Rehab staffing which is as follows:

3W – RT & MT (2 FTE)
2W – RT & MT (2.5 FTE)
1W – SMILE program
2 RT & 1 MT (2.0 FTE)
GF – AT & MT (1.5 FTE)
2 OT's going to all units (.5 FTE per unit)
Contracted Physical Therapy

On March 3, 2003 one of the RT's was absent and there was no coverage for his groups. We are reviewing coverage and how to provide coverage for activities in the event of staff absences.

In addition to the above staffing, each unit has group treatment programs provided by Nursing, Social Work and Psychology. During the past 60 days the Director of Rehabilitative Services has been working closely with the Nursing Department by having Rehabilitation Staff work cooperatively with the Clinical Nurse Specialists and Unit Coordinators on the other Units to plan and continue to schedule appropriate treatment Modalities, activities, and events for the patients. The Senior Recreation Center has been added to the Program Schedule for each Unit. The Occupational Therapist (2) will also plan and conduct psychosocial groups (Sensory Stimulation, ADL Training and Horticulture) in addition to assisting the CNS's with Feeding Programs. The Clinical Leadership Team does quarterly review of Active Treatment hours and adjustments are made to meet any deficits. (A copy of the report on active treatment hours is available for the date of the follow-up visit on March 3, which confirms the OIG observations.)

Individual Treatment Plans are developed by Multi-disciplinary Treatment Teams and implemented with consideration of the patients' level of physical and cognitive functioning.

NOTE: As indicated above, PGH has recently implemented a new Senior Recreation Center where patients can get off the unit and attend various programs. The Center modalities are available one day a week to patients from all units. In addition, forensic patients (housed on 3-West) attend every day. The program is designed to allow patients the freedom of choice in recreational, diversional / music and special events**.** The Center provides the opportunity for patients to interact with others outside of their present environment, similar to centers in the

community. A Sensory Stimulation Room is being developed with sensory lights and a large aquarium, which should be completed by the end of March. There will be four rooms set-up with activities scheduled and carried out in each of the rooms daily, based on patient's level of functioning. Pet Therapy, Gardening, and outside Entertainment Groups will be forthcoming. Unit based Program staff also have the opportunity to plan or request their own special activities or events for their patients on their scheduled days at the Center.

April 21, 2003 is our projected date to have completed the modification of our psychosocial treatment programs throughout the facility. We continually evaluate the effects of these programs on the outcome on their treatment goals.

Finding 3.1: Tours of the facility revealed that the hospital was clean, comfortable and well maintained.

Recommendation: None.

DMHMRSAS Response: The Department appreciates the OIG findings related to the environment of care at this facility.

Finding 4.1: PGH is currently reviewing and revising policies regarding behavioral treatment.

Recommendation: The OIG requests that this policy be forwarded for review upon its completion.

DMHMRSAS Response: The draft of Behavior Treatment Policy (Hospital Instruction #47) is in final review with the Clinical Leadership Team. (Draft copy attached.) An Implementation date of April 1, 2003 has been set. The facility and the Department would welcome the comments of the OIG regarding this policy.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO SECTONDARY INSPECTION REPORT
MARCH 6, 2001
OIG REPORT # 39-01

Finding 2.5: Cottage design for the most challenged individual does not properly accommodate equipment or storage.

Recommendation: Central Office DMHMRSAS staff should work closely with SEVTC leadership to develop an optional plan of storage of unused equipment and create an environment that meets the needs of swift evacuation and bathing for population that is consistently changing.

DMHMRSAS Response: We concur. SEVTC reports that they routinely remove unused equipment from the cottages. However, the more severe space problem is created by the presence of many pieces of individualized, large equipment needed for mobility, positioning, feeding, and lifting of clients. Several construction studies have been conducted by the Virginia Department of Planning and Budget for the past six years as a result of the crowded conditions noted by the OIG. These studies have resulted in suggestions from the Office of Architecture and Engineering that the cottages be expanded by the addition of new space, reduced in bed capacity and remodeled to increase useable space, or replaced with new construction. SEVTC is

cooperatively working with CO staff architects and engineers to improve the cottage space and design situation. As the OIG noted, SEVTC's cottages were not constructed for the current clients or services it now provides for.

6 Month Status Report: 01/01/02
SEVTC continues to work with the DMHMRSAS Office of Architectural and Engineering. Design and planning dollars were included in the 2002 Capital Bond Bill to address this concern.

OIG Comment – *Observations demonstrated that the facility has made efforts in storing unused equipment despite the ongoing problem with the basic design of the cottages. Resolution of this concern is contingent on proposed renovations. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
The Department's Central Office will once again put forth a capital improvement budget to be considered in the Capital Bond Bill for FY 2004.

SECTION THREE: STAFFING

Finding 3.1: Given the degree of impairment of the individuals residing within this facility, Southeastern Virginia Training Center has an inadequate ratio of direct care and professional staff to residents.

Finding 3.2: The facility currently contracts with a local psychiatrist for 20 hours per month.

Finding 3.3: There is considerable use of overtime at SEVTC.

Recommendation: None immediate. This is a longstanding problem that deserves more close study. The facility was designed, funded and staffed for a much less impaired population than currently resides there. This, combined with current low unemployment rates in Virginia further compounds the recruitment and retention of an enduring direct care workforce. The impact of the current level of staffing at SEVTC and SWVTC that has a similar situation will be the subject of future of OIG review.

DMHMRSAS Response: We concur. The Department plans to request funds for additional staffing and other needs for SEVTC during the up-coming legislative session. In the interim, a Quality Improvement Plan Committee, comprised of Central Office and SEVTC staff, was convened to evaluate SEVTC's staffing ratios, programs, and services. A subcommittee, led by the DMHMRSAS Medical Director, along with the assistance of CO Human Resources and SEVTC staff, was formed to conduct an analysis of the Psychiatrist functions and duties to estimate the number of psychiatrist work hours needed for improved medical care and treatment provided to SEVTC's residents. SEVTC will continue to make appropriate, timely discharges

and redeploy staff to critical areas. SEVTC will also continue to hire direct care positions, within the parameters of its current budget allocation. The Central Office will routinely review budget expenditures for purposes of determining opportunities for increasing direct care ratios within appropriations

6 Month Status Report: 01/01/02
The special Training Center allocation provided in 2001 to SEVTC helped to increase psychiatric and other essential clinical services and to increase direct service staffing. A gradual reduction in overtime is expected as the direct service staffing level increases.

OIG Comment *- Interviews revealed that the facility has increased the number of psychiatric hours with the special training center allocation. The facility is currently in the process of advertising and hiring additional direct care staff members but at the time of this February 2002 follow-up, that process had not been completed. Interviews with direct care staff related that overtime continued to occur but with less frequency in the past few months. According to the OIG monthly facility data monitoring report, the overtime hours of March 2002 are significantly less than January and February 2002. Because this has not been sustained for several months, this finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
SEVTC has added a physician and a psychiatrist, who both will start employment in mid-September 2002. The Center also has increased psychiatric and psychologist contracts; and has continued to recruit for other direct care positions - recreation, LPTA, COTA, rehabilitation technician, vocational technician, two afternoon shift supervisors, a half-time OT, and an additional 15 cottage direct care staff.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
MAY 29-31, 2001
OIG REPORT # 44-01

Finding 3.3A: The staff at SEVTC maximizes its efforts to provide the residents with active treatment opportunities despite staffing limitations.

Recommendation: 3.3A: Evaluate the need for increased professional staff and/or aides trained in conducting OT and PT activities.

DMHMRSAS Response: This need for increased professional staff and/or aides trained in conducting OT and PT activities has been evaluated and recommendations have been made based on the NVTC Settlement Agreement. Recommendations for increased professional and licensed assistant staffing at SEVTC have been submitted in the Department's budget request.

6 Month Status Report: 01/01/02

The Center has hired an additional ½ time OT. Other staff will be added as funds become available. One additional OT and one additional COTA will be added in the FY 2003 budget.

OIG Comment- *Interviews indicated that the facility has established hiring priorities. Direct care workers have been identified as the high priority in hiring as funding becomes available. The facility plans on hiring additional professional staff and has projected hiring of an additional OT and COTA. Clerical staff have been acknowledged to be a valuable additional but the facility will hire priority positions prior to adding to the clerical staff. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

SEVTC has had continuous recruit for priority positions - one COTA, one LPTA, one speech pathologist, and one recreation therapist. At this time, the Center has hired one speech pathologist and is still recruiting for the other positions.

Recommendation: 3.3B: Consider hiring a secretarial person to use the skill of professional staff more efficiently.

DMHMRSAS Response: The need for secretarial assistance at SEVTC has also been evaluated and would be beneficial; however, this is of a lower priority as compared to SEVTC's need for direct service staff members, professional staff, and qualified therapy assistance (COTAs, LPTAs, psychology assistants.). As these positions are filled, secretarial assistance will be reconsidered.

6 Month Status Report: 01/01/02

The facility continues to look to fill priority positions. SEVTC will also explore the possibility of obtaining clerical interns from surrounding schools and colleges.

OIG Comment- *Interviews indicated that the facility has established hiring priorities. Direct care workers have been identified as the high priority in hiring as funding becomes available. The facility plans on hiring additional professional staff and has projected hiring of an additional OT and COTA. Clerical staff have been acknowledged to be a valuable additional but the facility will hire priority positions prior to adding to the clerical staff. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

Direct care staffing continues to be a major priority at SEVTC. In addition to the recruiting for professional staff reported in January, the Center continues to recruit and hire direct service personnel for the cottages and for ancillary programs. The Center is also recruiting to fill two new evening shift supervisor positions.

Finding 4.3: All the space does not seem to be used in an optimal manner.

Recommendation: Consider the re-allocation of space and equipment and/or residents so that residents in wheelchairs are in a larger, more usable space. If this is not possible, consider renovations of the cottages where residents in wheelchairs reside.

DMHMRSAS Response: The allocation of space at this facility has been considered a number of times. The Department has developed plans for renovation of the cottages at SEVTC and these plans are represented in current capital improvement projects. Many of the residents require special wheelchairs and medical apparatus to maintain their daily lives and lots of space is required for freedom of movement. The Department has proposed to construct three new structures, constructed in three phases. These new buildings would be designed to provide for the room needed to work with persons with requiring wheelchairs a daily basis. As funding becomes available for capital improvement projects, construction of the new buildings at SEVTC will begin.

6 Month Status Report: 01/01/02
The Department waits for the Capital Bond Bill approval which will allow for the facility to begin the planning and design phase of the building improvement in FY 2003.

OIG Comment- *Interviews revealed that the facility has conducted several reviews regarding the use of space and has made a request for extensive renovations to the cottages as well as new construction as funding becomes available. The team was informed that these plans have been outlined in the capital improvements plan. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
The Department's Central Office will once again put forth a capital improvement budget request to the state Department of Planning and Budget.

Finding 4.4: Storage space is needed for unused equipment and excess supplies.

Recommendation: Review the current practice for storing unused equipment and excess supplies and develop alternative storage areas.

DMHMRSAS Response: Storage space has been reviewed, particularly in relation to item 3.2 and recommendations that the Center hire at least one rehabilitation engineer. The capital improvement project includes storage space for the cottage equipment.

6 Month Status Report: 01/01/02
See response to Finding 4.3 regarding potential for space improvement within this facility.

OIG Comment- *Interviews revealed that the facility has conducted several reviews regarding the use of space and has made a request for extensive renovations to the cottages as well as new*

construction as funding becomes available. The team was informed that these plans have been outlined in the capital improvements plan. This finding is ***ACTIVE.***

6 Month Status Report: 07/01/02
(Please refer to our Update for Finding 4.3) Some improvements in storage are anticipated with the employment of a rehabilitation technician, who will advise SVTC on proper utilization of, and any needed re-design of, existing equipment. Storage improvements are anticipated from enhanced preventive maintenance, rapid processing of older wheelchairs and equipment, and greater efficiency in parts storage.

Finding 8.1 The majority of staff interviewed indicated that shortages in direct care staff poses the greatest challenge for providing quality care to residents of the facility.

Recommendation: Continue to explore options for recruiting and retaining staff in these key positions.

DMHMRSAS Response: Concur. SEVTC will continue its recruitment and retention efforts for direct service staff members, professional staff, and qualified therapy assistance (COTAs, LPTAs, psychology assistants.). Current staff efforts include ongoing advertisement, flextime, shift differentials, and continuing education scholarships.

6 Month Status Report: 01/01/02
Since the last report, the Center has run a more extensive advertisement campaign which has produced more applications for positions. The advertising budget has increased by 50% and advertisements appear in newspapers weekly in larger block form. A link has been for job searchers on the SEVTC website regarding current position openings. Relationships have been established with the local Navy bases regarding SEVTC openings and job posting are given to persons exiting military though TAP classes. VEC and community college posting continue.

OIG Comment *– Interviews with supervisory staff indicated that the facility has made a concerted effort at securing more direct care staff. As noted in the progress report, advertising has been expanded and a greater applicant pool noted as a result. The facility has not completed the hiring of these positions and it is for this reason this finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
SEVTC remains committed to maintaining intensive recruitment efforts for all priority positions. The recruitment of direct service personnel remains a top priority effort for the Center.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
FEBRUARY 17-18, 2002
OIG REPORT # 54-02

Finding 1.1: The living environment in Building 29 was unsanitary and presented hazardous situations for residents.

Recommendation: Insufficient numbers of staff can not safely manage resident needs and maintain a safe environment. SEVTC needs to review practices for building maintenance to assure that cleanliness and safety standards are maximized within existing resources. This is not likely to be able to be permanently resolved without additional resources.

DMHMRSAS Response: The Center agrees that a safe and sanitary environment is fundamental. SEVTC maintains a lower staff: client ratio in this large cottage due to residents being higher functioning and in order to more richly staff cottages where clients have greater needs for individual care and supervision. While the relatively greater independence of this group of twenty clients makes a lower staffing ratio possible, it also creates special challenges for bathroom maintenance. The following steps have been taken in an effort to address the recommendation:

1. Staffing in this cottage will be increased using new funds;
2. Two new evening shift supervisor positions are being created for campus oversight with recently added funds on observation instrument will be put into place to assist in oversight activities;
3. Bathroom maintenance checks will be restored to an existing 30-minute day and evening resident check schedule. Similar bathroom checks will be scheduled hourly during the night;
4. Housekeeping will revisit cottages in the late afternoon to ensure that trash and significant problems are resolved before leaving campus;
5. Several clients who have previously mastered toileting programs, including flushing, will be re-evaluated and appropriate training re-instituted as necessary;
6. The team leader will conduct in-service training periodically regarding the above procedures; and
7. The team leader will follow-up to ensure that these procedures are being followed.

At this time, basic cottage sanitary maintenance at certain times of the day will remain a cottage staff function.

6 Month Status Report: 07/01/02
SEVTC continues to maintain a safe, sanitary living environment for its clients. Revised maintenance checks of all bathrooms continue**.** *Dr. Shrewsberry will provide fuller response.*

Finding 1.2: Improper disposal of a razor blade by a staff member was observed.

Recommendation: Assess the need to re-train staff on the proper disposal of sharps and hazardous waste.

DMHMRSAS Response: With one exception, all clients in this cottage shave with (or are shaved with) electric razors. The exception is occasional use of a disposable razor to shave the head of man who prefers this style. Safety razors and single- or double-edged blades would be very dangerous, but these razors and blades are not used in any Center cottage. Disposable razors are used with some residents in other campus cottages. Cottage staff have been reminded and have reviewed disposal of used disposable razors to ensure that this is done safely. A sharps box is maintained in every cottage.

6 Month Status Report: 07/01/02
New sharps containers were purchased and installed for each cottage and for the infirmary at SEVTC. Through special training sessions, cottage staff have been instructed in proper sharps disposal. SEVTC is monitoring staff compliance with proper sharps disposal; and, when indicated, will address instances of non-compliance through the supervisory process.

Finding 2.1: Staffing numbers were at the minimum required level.

Recommendation: Review staffing deployment to assure that patterns meet the level of supervision necessary to safely manage basic body functions as well as provide for active treatment needs of the residents.

DMHMRSAS Response: Deployment will be reviewed as new positions are added utilizing new funds. Recruitment for cottage staff positions has commenced. The facility will assure that staff are deployed to meet Medicaid minimums and to address activity in the various cottages.

6 Month Status Report: 07/01/02
SEVTC has been engaged in continuous recruitment of cottage staff and priority positions . Since January 2002, approximately 35 cottage staff have been hired. Cottage staff turnover continues to be a challenge for the facility.

Finding 3.1: Residents were observed to be engaged in a variety of leisure activities for a limited amount of time.

Recommendation 3.1: Continue to provide a variety of activities to address both the leisure and active treatment needs of the residents. Review staffing patterns to assure that the treatment needs of the residents are adequately addressed.

DMHMRSAS Response: Recreation staff have adjusted their schedules to concentrate more of their time on providing activities in the early evening hours and during weekend hours.

6 Month Status Report: 07/01/02

To assure that client treatment needs are adequately addressed, SEVTC has supplemented recreation staffing and has revised staff schedules to increase evening activities, such as skill-improvement and recreation.

SOUTHSIDE VIRGINIA TRAINING CENTER
RESPONSE TO INSPECTOR GENERAL REPORT- PRIMARY INSPECTION
DECEMBER 9 & 15, 1999; JANUARY 4 & 5, 2000; APRIL 3, 2000
OIG REPORT # 18-00

Finding 2.1: The facility has established procedures for the use of locked time-out and the use of restraints. This does include the use of "training restraints" or program restraints.

Recommendation: The appropriate use of "program restraints" will need to be considered in the reworking of the Human Rights regulations.

DMHMRSAS Response: Concur. SVTC tracks every type of physical and mechanical restraint it uses and has systems in place to prevent abusive practices. These systems include the Behavior Management Committee as well as the local Human Rights Committee to monitor programs to ensure that least restrictive options are utilized. SVTC does not use seclusion, and less than 1% of restraint use is classified as behavioral emergencies. The majority of restraints used at SVTC are for the purpose of deterring self-injurious behaviors. These restraints are typically mittens, which do not restrict movement, and are of short duration (1-5 minutes).

The Human Rights Regulations do not address the specific use of "program restraints" as these regulations are intended for broad-based use by state-funded facilities and private providers. However, specific guidelines regarding MR Training Centers' restrictive procedures, such as programmatic use of mechanical or physical restraint and time-out (not locked), are addressed in the Draft Departmental Instruction- *Behavioral Treatment Procedures,* when the restraint or time-out is part of a behavior management plan.

6 Month Status Report: 7/1/01

Currently the new Human Rights Regulations and Departmental Instructions are under administrative review.

OIG Comment - *The facility is awaiting the approved version of the DMHMRSAS directive, currently under review, in order to draft appropriate policies and procedures. This finding is* ***ACTIVE.***

6 Month Status Report: 01/01/02

The DMHMRSAS has refined medical, emergency and programmatic restraint definitions and the facility has adjusted their policies to the new definitions. Also, they will revise existing policies to be in compliance with the newly released Human Rights regulations that were recently passed. This will be completed early in 2002.

OIG Comment *– Interviews with administrative staff and review of documents indicated that the facility has adjusted its policies and procedures to address the new human rights regulations. Thirty standard operating procedures were submitted to the Central Office and local human rights committee for review on 2/28/02. All but four of those submitted have been approved at the time of this April follow-up visit. The training of staff is expected to be completed by July 1, 2002. Administrative staff indicated that it will be difficult for the facility to complete the training as required for the 1400 employees of the Center as the training tapes have not been forwarded by the Central Office. Administrative staff, department heads and other management staff have been trained. The facility plans on developing its own training materials if the tapes from CO are not forwarded in the very near future. Because facility staff have not completed training on the new Human Rights regulations, which includes the use of seclusion and restraint, this finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
SVTC will continue to ensure that staff are knowledgable about and comply with the new Human Rights Rules and Regulations as well as Departmental guidelines regarding these new rules and the Departmental Instruction on restraint use. SVTC reports that use of emergency restraints remain at near zero levels. Instances of emergency restraints at SVTC have numbered between 0-2 monthly since November 2001. SVTC has reviewed the new Human Rights Regulations for implementation. Based on that review, SVTC is revising applicable facility policies and procedures; and additionally, initiated supplemental staff training, which is scheduled for completion by 9/1/02.

Finding 3.1: Several disciplines at SVTC do not meet the staff-to-patient ratios established for Northern Virginia Training Center by agreement between the Commonwealth of Virginia and the Department of Justice.

Recommendation 3.1: Central Office DMHMRSAS staff should work closely with SVTC leadership to develop a clear plan for the current inadequate ratio of professional staff to residents at this facility.

DMHMRSAS Response: It is the general goal of the Department to implement a targeted approach to quality improvement to achieve professionally recognized clinical best practices in state facilities. The objective is to bring all state mental health and mental retardation facilities up to the active treatment and staffing levels provided in the Department of Mental Health, Mental Retardation and Substance Abuse Services' settlement agreements with the U.S. Department of Justice, under the Civil Rights for Institutionalized Persons Act. We will continue to work toward achieving this objective through the appropriate realignment of internal management practices, and resource allocation initiatives that are based on consumer and/or family choice.

In regard to SVTC, although the prior request for funding of DOJ-level staffing made by DMHMRSAS did not result in an increase to the FY 2001 SVTC budget, there has been some accumulation of funds in the first quarter. The accumulation of funds has been caused due to turnover and vacancies in SVTC 's Human Service Care Worker positions and others, including OT and Speech Pathology staff. There have been unexpected demands competing for these savings in addition to increased personnel costs associated with the re-organization of residential

units and overall strengthening of management oversight. Several examples of current demands include:

- $450,000 in costs for emergency repairs to boilers providing heat and hot water to SVTC, CSH and HDMC funds
- $150,000 set aside pending a problem analysis being conducted with Verizon re: issues with the campus phone system

Given requirements such as these, SVTC continues to take an incremental approach to establishing professional positions. Each decision to establish a professional position must be weighed against competing priorities within SVTC and support for the Petersburg Complex. Therefore, DMHMRSAS continues to believe the prudent approach to addressing the large-scale need represented by DOJ-level staffing is the legislative/addendum process which supports our staffing needs as originally pursued.

SVTC must operate within the parameters of its budget allocation, as do all other facilities. It is projected there will be no administrative savings to move into direct care positions at this time. However, they do routinely review budget expenditures for purposes of determining opportunities for increasing direct care ratios within appropriations.

Physical Therapy Staff

It is important to note that four (4) physical therapists and four (4) licensed physical therapy assistants are on board. These eight (8) positions have remained filled. SVTC has sought a contract physical therapist since April 2000 to dedicate to triennial evaluations of individuals not receiving PT services. Current discussions with a contract agency are showing some promise.

SVTC's Physical Therapy Department as a whole has experienced some change in staff that has had a supportive effect on therapists. After almost two years of recruitment efforts, a full time rehabilitation engineer was hired in April 2000 and remains on board. This position focuses on making wheelchair adaptations and is assisted by lab mechanics. An additional lab mechanic position was recently established to make a total of three (3) positions. Recruitment efforts for a part-time lab mechanic initiated in July 2000 continue as well. The PT Director is retiring in December; however, recruitment efforts are underway, and there are several candidates for the position.

Nutritional Management Staff (OT, Speech/Language)

As difficult as it is to recruit for occupational therapists and speech/language therapist positions, it is even more difficult finding candidates with nutritional management expertise. Such "swallowing specialists" may be recruited as either an OT or speech/language therapist. Both the Occupational Therapy and Communication Skills (speech/language and audiology) departments are continuously engaged in maintaining or replacing staff for both nutritional management as well as traditional clinical functions.

Over the last few years SVTC has worked hard to maintain at least three swallowing therapists; the staffing pattern has been two speech therapists and one occupational therapist. However, in the April 2000-November 2000 time frame, there has been significant turnover in these positions. The reasons for this turnover are that there is a high demand for these specialized

positions in the community, coupled with more competitive salaries. SVTC responses to the turnover situation included:

A speech/swallowing therapist that resigned in April to return to school was contracted with to continue her nutritional management work on weekends. A permanent replacement was hired in June. The weekend contract arrangement continues with the original speech therapist.

Both speech therapist swallowing specialists resigned during August-September 2000; both positions are being recruited for, and several applications have been received. It is estimated that these positions will be filled, given the availability of the applicant, within sixty days.

Two speech assistant positions were established with the hope that one full time equivalent will be devoted to nutritional management support. One position was filled on October 25, 2000 and she will dedicate 50% of her time to Nutritional Management Therapy. The remaining position was re-advertised and several candidates have applied. It is estimated that this position will be filled, given the availability of the applicant, within sixty days.

One OT swallowing specialist was hired May 2000, but resigned August 2000. A full-time OT staff dedicated to nutritional management is resigning effective November 30, 2000. Recruitment for these replacements has already begun.

Recruitment and retention

The normal recruitment of therapist positions is often extended over a 6-week period of time. Media approaches to recruitment have been nationwide through the Internet, professional publications, colleges and universities, and local newspapers. In addition, the facility has offered three educational scholarships over the last two years for OT and PT positions. An OT scholarship graduate will begin employment with SVTC in January 2001 in a newly-established OT position.

Retention of these valuable, but scarce professionals, is an ongoing concern particularly for swallowing therapists as noted above. SVTC has included an in-line adjustment for PT, OT and speech therapist positions in a recent proposal acting upon compensation reform.

Please rest assured the Department will continue to monitor all state facilities to ensure the continued progress in moving toward our staffing objectives and improving the quality of care to all constituents of the Commonwealth.

6 Month Status Report: 7/1/01
SVTC has continued to seek ways to increase staff in the therapies. Difficult-to-fill positions such as Speech Pathologists have been converted to (more available) Occupational Therapists. Other positions have been converted to Therapy Assistant positions. Since November 2000 SVTC has created a net increase of one Therapist and three Assistant Therapist positions. Several vacancies have been filled, and a part-time contract was established with a veteran PT to conduct triennial evaluations. This

incremental approach to strengthening the therapies has been helpful.

OIG Comment - ***There has been an ongoing process demonstrated through interviews to enhance professional staff within the facility. Plans are to continue these efforts. It is felt that census reduction will be the key for attaining appropriate staff to resident rations for those positions. This finding is*** *ACTIVE.*

6 Month Status Report: 01/01/02
SVTC has continued to seek ways to increase staff in the therapies areas. Regarding Therapy/Assistance Therapy positions, an additional Licensed Physical Therapist Assistant position was created and filled during the past six months. A part-time Physical Therapist position was discontinued after completion of triennial evaluations on all clients as recommended by the CRIPA consultant. Physical Therapy has gained two positions; and Occupational Therapy has gained four positions.

OIG Comment ***– Interviews indicated that SVTC has sought to increase professional staff as funding is available. The facility is currently under a hiring freeze but approval has been obtained through the Executive Steering Committee for positions viewed as critical. These hires, even though identified as critical, are still viewed as exceptions. The facility identified that it needs 43 positions in order to meet the same standards established through the settlement agreement between the Department of Justice and Northern Virginia Training Center. Nursing and direct care staff positions have been considered the priorities for replacement when vacancies occur. On the date of the inspection, interviews for the Director of Nursing position were taking place. During the past six months, SVTC added an licensed physical therapy aide position and a part-time physical therapist. The facility lost one occupational therapist and hired four. The facility has also lost one full time speech therapist, which is a difficult position to fill for this facility. SVTC continues to move towards census reduction. Fifteen persons have been placed in the community during the past six months. The facility has established a targeted reduction of between 30 to 35 persons each year until they reach the target census of 200 residents. This finding is*** *ACTIVE.*

6 Month Status Report: 07/01/02

SVTC continued to seek staff for the therapies via continuous recruit, although a commitment to hire requires approval by the facility's Executive Steering Committee. Also, the continuous recruit status of therapist position has been re-instated in the state Recruit system.

As of this writing, the SVTC therapies are as follows:

Occupational Therapy:
Therapist positions = 8, of which 7 are filled;
COTA positions = 4, of which 4 are filled;
Physical Therapy:
Therapist positions = 4, of which 3 are filled;
LPTA positions = 5, all of which are filled
Speech Therapy:
Therapist positions = 1.5, of which 1 is filled;
Speech Assistant positions = 3, of which 2 are filled.

Finding 8.1: SVTC does not have a clear vision regarding its evolving role in the treatment of the Mentally Retarded in the Central Virginia area.

Recommendation: A plan should be developed regarding the role and size of SVTC over the next several years.

DMHMRSAS Response: The DMHMRSAS Comprehensive State Plan for 2000-2006 proposes that by the end of 2006 SVTC would consist of 249 beds. The reduction from SVTC's current census of 450 will be accomplished by the placement of clients in appropriate community settings and supported by the choice of the client and their family or guardian. To accomplish this goal, SVTC and the CBSs in its catchment area have begun to work more collaboratively regarding treatment planning and community discharge planning and placements. The vision for SVTC can be described as a regional Residential Facility serving clients with severe/profound mental retardation who require extensive supports for behavior and/or physical needs.

6 Month Status Report: 7/1/01

Since the initial plan of correction was developed the SVTC census has dropped from 450 to 423. The closing of the last North Campus residential building is in progress. Transitional staffings including CSB staff are held to develop a service plan for the community placement. SVTC conducts transitional visits of clients to community settings prior to discharge and follow-up visits after discharge. Individuals with physical needs at the skilled level are served in collaboration with Hiram W. Davis Medical Center (HWDMC), when necessary. Community individuals that need intensive behavior supports are placed in the intensive behavior unit when necessary and plans for return to community placement developed.

OIG Comment - *The facility has designed a plan to focus on census reduction and currently has an identified 100 residents appropriate for discharge pending the availability of appropriate community placement. This finding is* ***ACTIVE.***

6 Month Status Report: 01/01/02
Building #3 & 4 have been closed, all clients now reside on the south campus. The goal is to reduce the census in cottages to 16; currently 10 of 13 duplexes have a census of 16 or under. Community placement has slowed based on availability of community resources. SVTC has placed 11 customers since July '01 in the community. DMHMRSAS has approved Medicaid waiver money for 39 consumers statewide based on a first come, first serve basis. SVTC has 53 clients recommended for placement who have active CSB participation; CSB is the responsible entity to request the Medicaid Waiver dollars. SVTC is in contact with CSBs regarding placements with two clients projected for placement in February.

OIG Comment *- Interviews revealed that 15 persons have been placed in the community since October of last year. SVTC has a target of placing between 30-35 persons a year. The targeted census reduction is for the facility to have an operating capacity of 200 beds. Placement has become more difficult as those targeted for discharge are more medically fragile than those previously successfully placed. This area of the Commonwealth would benefit from the development of a Center of Excellence, which serves community residents and is modeled after the Northern Virginia Training Center program. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
SVTC has made progress in reducing the census of client living areas. Since the last report, SVTC has had five discharges. At this time, 12 out of the 14 facility duplexes have a census of 16 or less, leaving only two duplexes with a census of 16 or more: C-18/19, 17 clients; and C-28/29, 18 clients. In addition, SVTC will continue to address census reduction in those two duplexes, as well as all other living areas across the campus, by monitoring vacancies and by making client movements if placement is deemed appropriate for the client.

SOUTHSIDE VIRGINIA TRAINING CENTER
RESPONSE TO SECONDARY
JANUARY 29, 2001
OIG REPORT #36-01

Finding 1.5: SVTC uses the data collected to initiate performance improvement projects.

Recommendation: Expand upon this performance improvement process to foster a targeted approach to comprehensive system enhancement. Other facilities, particularly other training centers may benefit from the knowledge as to how this risk management information system is used to lessen the ongoing risks of recurring injury to individuals as well as the prevention of injury for others with similar risk factors.

DMHMRSAS Response: We concur. SVTC has developed numerous reports in addition to the standard ones available with the client incident database in order to give reviewers the injury data that are of greatest need. These reports are developed and provided as various users of information (internal facility departments, II) Teams, etc.) identify a need. The SVTC Office of Quality & Risk Management also provides tailor-made reports when special information needs arise. The availability of information from the database will be enhanced by developing local computerized access to data-on-demand by users. Input from users will be sought to craft reports appropriate to their needs. In addition, the facility will establish a formal process for examination of facility-wide data and problem/opportunity identification by July 25, 2001. This review process will be in addition to those occurring at the department and ID Team levels. Any quality improvement projects undertaken as a result will be monitored and interventions/results shared with other facilities, departments, ID Teams that may benefit from project replication. We will ask the Facility Director to forward a description of their incident database and their procedures for utilizing the data for quality improvement.

6 Month Status Report: 7/1/01
The SVTC Risk Management Committee identified at its July meeting a number of facility-wide indicators it will track on a quarterly basis.

OIG Comments – *Interviews and a review of current performance initiatives revealed that a number of identified projects are linked to the information obtained during the investigations and reviews of critical incidents. This finding is ACTIVE.*

6 Month Status Report: 01/01/02
With regard to Performance Improvement efforts using incident data, the Risk Management Committee began reviewing data/graphs on listed topics. Falls by day of the week was identified as an area that warranted further review due to much higher than average numbers on at least one day of he week. A spreadsheet was created for the Quarterly Falls Assessment data from the Client Incident Database to allow reviewing and graphing of data across all quarters and data types. This allowed us to identify two days of the week that have higher than normal fall

frequency. The spreadsheet was shared with Central State Hospital for their use. Central Office has encouraged Facility Directors to share promising quality improvement strategies at the periodic Facility Directors' meetings.

OIG Comment *– Interviews indicated that the facility in conjunction with the Risk Management Committee (RMC) reviewed the falls data to determine whether day(s) of the week was a significant factor contributing to the number of falls occurring. A review of raw data regarding incidents went back 2 ½ years with several different days coming to the forefront without any actual significance being determined.* ***No current projects have been identified as a result of the available data****. The facility risk manager and the RMC (which meets monthly) conduct on-going reviews of critical incidents as well as other data to determine if quality improvement initiatives are warranted. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02

The SVTC Risk Management Committee reviews client incident data monthly, as does each unit safety and wellness team. A fall assessment policy and procedure was developed by the Nursing Department and went into effect on May 1, 2002. All clients are being assessed for fall risk, and the level of risk will be entered into the facility database to allow the Risk Management Committee to study falls, particularly repeat falls, by those at risk. The Risk Management database has already been revised to accommodate the information.

Fall assessments are performed by the facility nursing staff on all new admissions and on existing clients as part of the annual ID Team planning process. Clients are also assessed after a fall and after a change in health status. The ID Team meets whenever a client falls to determine if interventions are warranted; and staff are instructed accordingly.

Southern Virginia Mental Health Institute
RESPONSE TO SNAPSHOT INSPECTION
May 6 – 7, 2002
OIG Report # 60-02

Finding 1.1: The facility was clean, comfortable and well maintained.

Recommendations: Maintain this environment while continuing to explore additional ways of updating this environment.

DMHMRSAS Response: DMHMRSAS concurs and appreciates the recognition of SVMHI's efforts to maintain a clean and comfortable facility. SVMHI plans to continue up-dating the environment through use of volunteer efforts.

Finding 2.1: Staffing patterns were consistent with defined facility expectations for evening coverage.

Recommendation: Continue to maintain staffing patterns for providing adequate coverage.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of SVMHI's staffing patterns for evening coverage. SVMHI is committed to maintaining appropriate staffing levels, despite a challenging job market.

Finding 2.2: Patients identified the nursing staff as having the most significant impact on their recovery process.

Recommendation: With identified concerns regarding the use of overtime and recruitment and retention problems state wide for nursing staff, this facility needs to formally recognize the efforts of this group of workers identified as the most helpful by patients.

DMHMRSAS Response: DMHMRSAS is pleased with the OIG finding that patients view the SVMHI nursing staff as significant to the recovery process. SVMHI is aware of the valuable contribution of its nursing staff, and makes regular efforts to acknowledge its nurses. Annually, SVMHI recognizes Nurses' Week both at the facility level and the unit level, but at the time of the OIG's visit, arrangements had not been finalized. The facility also makes every effort to recognize the individual efforts of the nursing staff on a case-by-case basis throughout the year.

Finding 2.3: SVMHI is reducing funding for staff training for FY 2003.

Recommendation: Work with the Central Office to formulate availability to continue career advancement education for professional and direct care staff.

DMHMRSAS Response: DMHMRSAS concurs. The Central Office of Human Resource Development will work with SVMHI to explore creative ways of continuing career advancement education for professional and direct care staff, to include shared training efforts with other facilities.

Finding 3.1: Evening active treatment and leisure activities were available for patients.

Recommendation: Continue to develop programming choices for patients that addresses individual needs.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of the evening programs provided to SVMHI patients. SVMHI, through its Psycho-social Rehabilitation Committee, will continue to develop programming choices that address individual needs. To better assist identification of patterns of patient need, SVMHI recently adopted a modified version of the computerized scheduling and attendance program used at a sister facility. This program will guide clinical decisions regarding the expansion or reduction of specific groups or activities.

Finding 3.2: Treatment planning is individualized and designed to meet the patients' treatment needs.

Recommendation: Continue to actively involve the patients in their treatment planning process.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of SVMHI's clinical accomplishment regarding individualized treatment planning. SVMHI is committed to continuing involvement of patients in the treatment planning process.

Finding 3.3: SVMHI has closed the token store.

Recommendation: None.

DMHMRSAS Response: None.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO SECONDARY INSPECTION
MARCH 19-20, 2001
OIG REPORT # 40-01

Finding 1.2: Pony walls in the C Building are potentially dangerous and increase this unit's ward like appearance.

Recommendation: Proceed with the planned renovation and relocation of the adolescent services unit into the main Bagley Building.

DMHMRSAS Response: As is noted in the report the planning for the renovation of space in the Bagley Building has been underway for some time. An identified problem with the plumbing system will further delay the actual move of the adolescent patients into the Bagley Building. However, funds have been identified to accomplish the renovation and the plumbing repairs. It is expected that the renovation and completion of the plumbing repairs will be accomplished by February 2002. After completion of these projects, a date to remove the Adolescent Unit will be selected that will ensure a smooth transition into the Bagley Building.

6 Month Status Report: 01/01/02
The plumbing repairs proceeded ahead of schedule and were completed in November, 2001. A contractor has been selected to complete final renovations in preparation of the Adolescent Unit relocation. SWVMHI now expects this relocation to be placed in mid to late January 2002 barring any unforeseen circumstances or delays.

OIG Comment – *Interviews and observations demonstrated that efforts to relocate the adolescent unit continue. At the time of the follow-up visit, the completion of the transfer was slated for before the end of March. Because the renovation has not been completed, this finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
Planned renovation and relocation of the Adolescent Services Unit into the main Bagley Building was completed on January 21, 2002. The B Building (former Adolescent Unit) is now closed to SWVMHI patient occupancy.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO PRIMARY INSPECTION
DECEMBER 4-5, 2001
OIG REPORT #51-01

Finding 3.2: There is inadequate space for effective programming.

Recommendation: SWVMHI working closely with the Central Office in exploring options for expanding programming space.

DMHMRSAS Response: SWVMHI provides off unit programming in the Blalock and Auditorium Buildings, which have space limitations due to the location of staff offices in these areas. Renovation of the Harmon building will provide for additional Central Program space by allowing staff to relocate to this area. SWVMHI and the Central Office Architectural and Engineering Office have worked together on plans to renovate the Harmon Building for several years. The Institute has designated a portion of their FY 02 operational funds to begin this renovation and Central Office has set aside Asbestos Abatement monies to repair floors and walls subsequent to the removal of asbestos. Plans are underway to contract for these initial repairs, which will allow for some limited relocation of offices. As additional funds are identified, the renovation will be expanded in order to ultimately establish sufficient program space in the Blalock and Auditorium Buildings.

6 Month Status Report: 07/01/02
The Bagley, Blalock and Auditorium Buildings comprise the Patient Care area at SWVMHI. In order to expand program space, SWVMHI is renovating the first floor of Harmon Building so that staff offices can be moved out of the Blalock and Auditorium Buildings, thereby creating additional options for program space in the Patient Care area. The facility contracted with the Department of Corrections (DOC) Construction Unit for repair/painting of walls and the installation of floor covering on the first floor of the Harmon Building. Renovation began in late July, and completion of this phase is anticipated at the end of October 2002. As additional facility funds are available, window air conditioners, computer/telephone service and Life/Safety improvements will be accomplished to facilitate relocation of staff offices to the Harmon Building.

OIG Comment (September 2002) – *Interviews with administrative and treatment staff demonstrated that the facility continues to work towards the goal of designating additional space for psychosocial rehabilitation programming. It was learned that the facility has contracted with the Department of Corrections Construction Unit for completion of the necessary renovations of the Harmon Building. As these renovations have not been completed at the time of the inspection, this finding remains* ***ACTIVE.***

Status Report: 10/02
The Department of Corrections Construction Unit has completed all of the work requirements under their contract in the Harmon Building as of 10/31/02. Renovations are projected to be final on or about January 1, 2003. SWVMHI will install phone and computer lines as funding is available. Once installation is complete, staff offices can be moved out of the Blalock and Auditorium Buildings,

thereby creating additional options for program space in the Patient Care area.

Finding 4.1: The facility has been working towards a fully integrated psychosocial rehabilitation program.

Recommendation: Continue to enhance this program while focusing on renovations that would allow for increased programming space.

DMHMRSAS Response: (See Response to 3.2 above regarding efforts to increase space.) SWVMHI will continue to improve assessment, treatment planning and therapeutic programming using psychiatric rehabilitation technology of which a key component is involving patients in making choices that impact their future. SWVMHI will continue to expand the psychiatric rehabilitation/therapeutic services offered based on patient's needs and preferences. Patients will be surveyed periodically regarding their opinions of the programming offered and whether they meet their needs. Central Rehabilitation Service/OT/RT and other staff will continue to be supervised on the specific competencies needed to ensure provision of psychiatric rehabilitation services. In addition, SWVMHI will explore the expansion of psychiatric rehabilitation curriculum to include vocational, educational and social offerings in order to provide for variety and enhanced services. These curriculum offerings are particularly appropriate when patients do not have control over future living choices.

6 Month Status Report: 07/01/02

SWVMHI will continue to improve assessment, treatment planning, and therapeutic programming using psychiatric rehabilitation technology of which a key component is involving patients in making choices that impact their future. SWVMHI will continue to expand the psychiatric rehabilitation/therapeutic services offered based on patients' needs and preferences. Patients are surveyed quarterly regarding their opinions of the programming offered and whether they meet their needs.

SWVMHI resources are being directed to the assessed needs of the patient population, which has resulted in the current focus on engagement and readiness development (which are two of the phases of psychiatric rehabilitation conceptualized by the Boston Center for Psychiatric Rehabilitation). In addition, SWVMHI will explore the modification and expansion of psychiatric rehabilitation curriculum to include vocational, educational, and social offerings in order to better meet patient needs based upon assessment and patient preferences. These curriculum offerings are particularly appropriate when patients do not have control over future living choices.

Central Rehabilitation Services/OT/RT and other staff at SWVMHI will continue to be supervised on the specific competencies needed to ensure provision of psychiatric rehabilitation services. Quarterly reviews of staff competencies, skills, and practices are completed and the results included in the quarterly Quality Management reports to the facility Quality Management Committee.

OIG COMMENT (September 2002): *Interviews were conducted with administrative and program staff. In addition, members of the team reviewed program schedules and attended several active treatment groups. Records were reviewed to determine the degree in which active treatment programs were integrated into the treatment process. There was evidence that SWVMHI continues to enhance the psychosocial rehabilitation model within the facility-at-large. This was reflected in the interviews, observations and document reviews. Consultation and training from the Boston Group is scheduled to continue working with staff in ways to assure that the principles of the recovery model generalize to unit management. As this project is underway but not completed, this finding remains* ***ACTIVE***

Status Report: 10/02

The Rehabilitation Department at SWVMHI continues to enhance and monitor the Psychiatric Rehabilitation (recovery enhancing) programs through an ongoing Quality Management program. Indicators this year continue to track Quality of Programs, Effectiveness of Programs and Patient/Staff Satisfaction with Programs.

Staff are supported through training and technical assistance to become competent in the application of skills and technologies of rehabilitation service delivery. Specific Quality Management Indicators are as follows:

- Indicator #1 - Ensures, through supervision and coaching, that supervisors regularly observe and document the quality of practitioner's skills during the service delivery session.
- Indicator #2 - Documentation reviews to ensure standards of Treatment Planning, progress note documentation and that patient is progressing toward established objectives within designated time frames.
- Indicator #3 - gives patients and staff a survey tool by which they can express opinions specific to Rehabilitation programming.

Additionally, the Rehabilitation Department of SWVMHI staff continue to work closely with each Unit Director and Treatment Team in reviewing the menu of services, changing the components to meet patient needs. Recent additions to the provision of services include:

- Individualized programming for the Geriatric population
- Short term fast tracked skill program for patients in the Admissions Unit
- Recovery readiness program for patients in the Admissions Unit
- Afternoon enrichment sessions for Extended stay patients
- Weekly LEAP (Leadership, Empowerment, and Advocacy Program). Consumers from the local Clubhouses assust SWVMHI patients gain skills and knowledge that will support re-entry to desired communities.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO SNAPSHOT INSPECTION
September 12, 2002
OIG REPORT #69-02

Finding 1.1: Tours of the facility demonstrated that the environment was clean, comfortable and well maintained.

Recommendation: Continue to focus on the provision of providing a safe and comfortable therapeutic environment,

DMHMRSAS Response: Southwestern Virginia Mental Health Institute will continue to focus on providing a safe, secure environment for the clients. The Security Enhancement System, fully implemented last year, continues to provide enhanced patient safety. Security staff makes regular rounds on all shifts with emphasis placed on patient care and treatment areas. Security staff spend additional time in patient areas where acuity is the highest. Ensuring patient safety and comfort are maintained are areas of major focus at SWVMHI.

Finding 2.1: Staffing patterns were noted to be consistent with facility expectations.

Recommendations: Maintain staffing patterns that meet facility expectations for patient safety and therapeutic involvement.

DMHMRSAS Response: This year, all staffing patterns for each unit at SWVMHI were reviewed and revised to establish adequate levels of appropriate nursing staff on a consistent basis across the week. This has assisted in more efficient use of nursing staff resources as well as enabling the Staffing Nurse Coordinators to deploy available staff to areas of highest acuity. A task force of direct care staff and nurse managers was formed two months ago and has met three times thus far to assist scheduling practices. **Several goals of this group are:**

- To promote staff ability to "self schedule" within certain parameters
- Maintain the needed staffing patterns.
- Consider weekend duty incentives as budgetary demands allow.

A standing Nursing Staffing committee continues to meet monthly membership includes:
- Facility Director
- Human Resources Manager
- Nursing/Human Resource employees.

Finding 2.2: SWVMHI celebrated Nurses Appreciation Week through a variety of creative activities and events.

Recommendation: Continue to find ways to recognizing and supporting the nursing staff.

DMHMRSAS Response: DMHMRSAS encourages the celebration of Nurses Week. At SWVMHI, employee work profiles for nurse managers are being revised to include an element related to positive recognition of staff that will be evaluated annually. An employee pole determined the following recognitions to be meaningful:

- "Employee of the month" plaques
- Letters published in the newsletter
- Food recognition events
- Opportunities in meetings to acknowledge achievements

Quarterly Nursing Forums continue to be held, and staff input is acknowledged as appropriate.

Finding 3.1: SWVMHI continually reviews and implements programs that will enhance the principle of the recovery model throughout the facility.

Recommendation: Continue efforts to broaden the principles of recovery within this facility.

DMHMRSAS Response: The Rehabilitation Department at SWVMHI continues to enhance and monitor the Psychiatric Rehabilitation (recovery enhancing) programs through an ongoing Quality Management program. Indicators this year continue to track Quality of Programs, Effectiveness of Programs and Patient/Staff Satisfaction with programs.

Employees are supported in becoming competent in the application of skills and technologies of rehabilitation service delivery through training and technical assistance. Specific Quality Management Indicators are as follows:

- Indicator #1 - Ensures, through supervision and coaching, that supervisors regularly observe and document the quality of practitioner's skills during the service delivery session.
- Indicator #2 - Documentation reviews to ensure standards of Treatment Planning, progress note documentation and that patient is progressing toward established objectives within designated time frames.
- Indicator #3 - gives patients and staff a survey tool by which they can express opinions specific to Rehabilitation programming.

Additionally, the Rehabilitation Department of SWVMHI continues to work closely with each Unit Director and Treatment Team in reviewing the menu of services, changing the components to meet patient needs. Recent additions to the provision of services include:

- Individualized programming for the geriatric population
- Short-term fast tracked skill program for patients in the Admissions Unit
- Recovery readiness program for patients in the Admissions Unit
- Afternoon enrichment sessions for Extended stay patients
- Weekly LEAP (Leadership, Empowerment, and Advocacy Program) Consumers from the local Clubhouses assist SWVMHI patients gain skills and knowledge that will support re-entry to desired communities.

Finding 4.1: Record reviews revealed that "safety net" crisis plans were not consistently developed for patients at the time of discharge.

Recommendation: Develop and document crisis intervention plans as a routine part of the clinical discharge process.

DMHMRSAS Response: Discharge planning, including crisis planning, is under the joint purvue of the facility and the Community Service Board responcible for the client, SWVMHI has educated and reminded facility and CSB staff regarding the importance of including a crisis

plan for all clients being discharged. The CSB After Hours Crisis number, is designated as the routine crisis plan by the Discharge Protocols for Community Services Boards and Mental Health Facilities and is included in all cases. Pursuant to Section 5.2 of the DMHMRSAS Discharge Protocols, "when specialized crisis plans are recommended, Facility Staff shall notify the CSB that a specialized crisis plan needs to be developed as part of the final discharge plan". The facility willnotify all CSBs in the region of this finding on the part of the OIG seeking to ensure responsiveness to the need for a crisis plan.

SOUTHWESTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
APRIL 24-26, 2001
OIG REPORT #43-01

Finding 3.5: The facility has conducted several reviews regarding the use of overtime.

Recommendation: The ongoing and seemingly indefinite use of overtime is not an efficient use of state resources. DMHMRSAS Central Office should review this staffing pattern closely with SWVTC staff.

DMHMRSAS Response: As result of the collaborative reviews conducted regarding the use of overtime, SWVTC has hired temporary and part-time employees instead of permanent employees; utilized non-direct care employees in service provision; kept other than direct care service positions vacant in order to generate funds for direct service; lowered direct care coverage when client safety allowed and consolidated supervision/managerial duties to create additional direct care staffing. All of these efforts, and many others have been helpful, but are not adequate to meet all staffing needs. Central Office is presently reviewing staffing needs related to the next biennium budget request.

6 Month Status Report: 01/01/02
The addition of one-time funding for staffing has helped to reduce overtime. Overtime use has been reduced from an average of 95 hours per day to 32 hours for the month of November, a 67% reduction in overtime use. Additional reductions are expected when 29 recently employed Human Care Service Worker's complete pre-service training.

OIG Comment - *Interviews with administrative and direct care staff reflected the benefits the facility have experienced from the additional funding provided, which enabled the facility to hire a number of temporary full-time employees with benefits, adding significantly to the workforce. These positions have resulted in a dramatic drop in the use of overtime. As there was a question regarding the continued availability of these positions because of budget concerns. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
Overtime continues to be reduced from the levels at the time of the IG survey. During the past 9 weeks there has been an increase due to several behavioral and medical resident conditions and increased leave demand during warm weather

months. Overtime has averaged 51 hours per day for this period-a 50% reduction since the time of the IG survey but an increase of 19 hours per day since the last report. When the acute resident need problems are corrected, we should see a return to the 30 to 35 hours per day range of November 2001 through April 02. SWVTC received official word 5/29/02 that the additional funds received in Nov. 01 have been approved for the FY 03/04 budget.

OIG COMMENT (September 2002): *This facility continues to monitor and actively seek to reduce the number of mandatory overtime hours. As noted, there was an increase in its use during the summer months, which was reported as due to the increase requests for need to cover vacation time as well as patient treatment and management concerns. Interviews with 12 staff members verified the increase and 8 of the 12 spoke of concerns that the situation will reverse itself to resemble the overtime demands of the previous year. Strategies are in place to diminish the likelihood that this will happen, but it becomes a distinct possibility in times when funding resources are limited. It will be important for this facility to be able to maintain adequate direct care staffing numbers in order to provide a safe and habilitative environment. This finding remains* ***ACTIVE.***

Status Report: 10/02

Strategies are in place to limit mandatory overtime to that which is absolutely essential to maintain a safe, therapeutic environment. The HSCW positions funded under the budget increase in FY 02 have been maintained despite the current budget reduction. Overtime should remain at significantly lower levels than during the initial IG survey.

Finding 3.7: There is a shortage of key staff in several key professional positions.

Recommendation: Review staffing patterns and functions to determine optimal levels required to effectively implement and follow-up on active treatment needs of the residents and provide adequate supervision of staff for optimal facility operations. This may not be able to be enhanced effectively without an increase in staffing.

DMHMRSAS Response: SWVTC has hired temporary and part-time employees instead of permanent employees, utilized non-direct care employees in service provision, kept other than direct care service positions vacant in order to generate funds for direct service, lowered direct care coverage when client safety allowed and consolidated supervision / managerial duties to create additional direct care staffing. All of these efforts and many others have been helpful, but not adequate to meet all staffing needs. The facility continues to review staffing patterns and utilization to determine optimal level based on their current staffing levels. Plans identifying SWVTC staffing needs to meet NVTC/DOJ levels have been submitted to Central Office by the facility with its last submission on July 24, 2001.

6 Month Status Report: 01/01/02

Additional one-time funds have resulted in improvements in HCSW's staffing patterns. SWVTC is in the process of attempting to hire a Family Nurse Practitioner and Two RN's.

OIG Comment - *Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
A Family Nurse Practitioner has been hired to support the work of the physician. In addition, two additional nurses have been hired and will begin work in June 02. The facility believes they will be able to add a .5 FTE activity therapist at the start of the fiscal year and are hoping to find the funds to add a full time Ph.D. Psychologist.

OIG COMMENT (September 2002): ***Interviews with administrative staff indicated that the facility continues to prioritize the hiring of additional staff as funding allows. After securing additional direct care staff with the additional funds this facility received in 2001, SWVTC placed a priority in securing a family nurse practitioner to assist with the oversight and provision of primary medical care within the facility. This person has been hired and has made significant contributions to the care of the residents in a relatively short period of time. Other priorities have been established but not realized to date. This finding remains*** *ACTIVE.*

Status Report: 10/02
The positions created in FY 02 have been and remain filled. Other priorities will be met as funding allows. The recent budget reductions will clearly have some negative impact on the facility's ability to continue the staffing enhancement process.

Finding 3.8: The facility has used the combining of several key administrative positions in orders to stretch resources.

Recommendation: SWVTC work with Central Office in reviewing this practice to assure effective coverage of key functions, particularly the supervision of staff.

DMHMRSAS Response: SWVTC will continue to review utilization of current staff, however, direct care staff receives priority in recruitment and hiring. In 2000, SWVTC reorganized its staff responsibilities to create the positions as indicated through its collaborative reviews with DMHMRSAS. Reorganization allowed them to designate one staff person as a full time Risk Manager and one person to provide part of his time to complete Abuse/Neglect investigations. They have also consolidated supervision in the residential living units that allowed them to hire a Physical Therapist, a Physical Therapist Assistant, an Occupational Therapist, and an Occupational Therapist Assistant. These changes have resulted in improvements in their risk management program, abuse/neglect investigation process, physical and occupational therapy.

6 Month Status Report: 1/01/02
The facility has hired a Nurse Practitioner. The Nurse Practitioner will begin

employment in February and she will assume the role of Director of Nursing, which will relieve the Medical Director.

OIG Comment - *Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02

A Family Nurse Practitioner and two additional nurses have been hired. The FNP supports the work of the physician and serves as Director of Nursing. If the facility is to find funds for a Ph.D. Psychologist, this position will have a resident caseload and serve as Director of Psychology.

OIG COMMENT (September 2002): Interviews with administrative staff indicated that the facility continues to prioritize the hiring of additional staff as funding allows. After securing additional direct care staff with the additional funds this facility received in 2001, the facility placed a priority in securing a family nurse practitioner to assist with the oversight and provision of medical care within the facility. This person has been hired and has made significant contributions to the care of the residents in a relatively short period of time. Other priorities have been established but not realized to date. This includes the hiring of a PhD psychologist, which is referred to in OIG Report #68-02. This finding remains ACTIVE

Status Report: 10/02

Please see response to Finding 3.7 above. Now that HSCW, FNP, and Nursing staffing priorities have been met, additional staffing enhancements will be made as resources allow. The next priority in this enhancement process is the hiring of a Ph.D. Psychologist to serve as Director of Psychology.

Finding 8.1: Staff interviewed identified the required amount of regular mandatory overtime as the primary factor in increased job dissatisfaction and low morale.

Recommendation: SWVTC works with Central Office in reviewing the adequacy of direct care positions with a goal of addressing areas of staffing shortages.

DMHMRSAS Response: SWVTC will continue its efforts to maximally utilize available staff. See 3.5, 3.8, 4.1, 5.1, 5.2 and 5.3 for demonstrated examples of SWVTC's efforts to increase direct service staffing. In addition, creative methods for working overtime when needed have been developed (i.e., Employees can and do “split” overtime shifts so that two or more employees can cover an eight hour absence. When overtime is needed, employees are polled to determine who would be willing to work the overtime before anyone is mandated to work over. An employee who volunteers to work overtime has his/her name moved to the bottom of the

mandatory overtime list. Professionals/managerial staff are sometimes utilized to take clients to medical appointments, off-campus shopping, etc.). But overtime is still required daily to meet all client service needs. Central Office is presently reviewing the staffing needs of all the training centers, including SWVTC, for the next biennium budget.

6 Month Status Report: 1/01/02
Please refer to section 3.5 response. Overtime has been reduced by 67% as a direct result of additional one-time funds and will be reduced even farther when 29 newly hired HCSW's complete pre-service training.

OIG Comment - *Interviews with direct care staff reflected a significant change in the morale since the previous inspection at the facility. Staff related that there was less overtime, which enabled them to feel more confident in being able to meet important personal commitments. This has resulted in staff feeling more positive about their jobs and SWVTC as an employer. Although many expressed being pleased by the recent hiring, they also expressed concern regarding whether the gains could be sustained because of funding issues. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
Refer to section 3.5 response. The 29 HSCW positions were filled by 2/02. This has resulted in a dramatic reduction in overtime levels from the time of the initial IG survey. SWVTC received official word 5/20/02 that the funds added in November 01 have been approved for continuation in the FY 03/04 budget.

OIG COMMENT (September 2002): *This facility continues to monitor and actively seek to reduce the number of mandatory overtime hours. As noted, there was an increase in its use during the summer months, which was reported as due to the increase requests for need to cover vacation time as well as patient treatment and management concerns. Interviews with 14 staff members verified the increase and 8 of the 14 spoke of concerns that the situation will reverse itself to resemble the overtime demands of the previous year. Strategies are in place to diminish the likelihood that this will happen, but it becomes a distinct possibility in times when funding resources are limited. It will be important for this facility to be able to maintain adequate direct care staffing numbers in order to provide a safe and therapeutic environment. This finding remains* ***ACTIVE.***

Status Report: 10/02
Strategies are in place to limit mandatory overtime to that which is absolutely essential to maintain a safe, therapeutic environment. The HSCW positions funded under the budget increase in FY 02 have been maintained despite the current budget reduction. Overtime should remain at significantly lower levels than during the initial IG survey.

SOUTHWESTERN VIRGINIA TRAINING CENTER
RESPONSE TO SNAPSHOT INSPECTION REPORT
December 2 & 3, 2001
OIG REPORT #50-01

Finding 2.2: Staff verbalized an increase in morale over the past several months.

Recommendation: Look for opportunities for staff participation as practices of leave time use and self-scheduling are being discussed.

DMHMRSAS Response: Increase in morale is a result of the enhanced staffing noted in other findings, thus allowing for a reduction in overtime and more opportunities for leave usage. The SWVTC Coverage Committee is utilized for planning and review of leave/scheduling practices for HCSW's. HCSW representatives from each unit and shift who are members of this committee will be sent to all living units to ensure that HCSW's are aware of issues being discussed and have the opportunity to provide input through their representative or through unit supervisors.

6 Month Status Report: 07/01/02
Refer to 2.1 above for status report. Coverage Committee continues to meet. Approval of the additional funds for the upcoming budget year should help assure employees that the additional staffing levels will continue. Correction of the acute resident medical and behavioral problems will allow for a reduced need for "one-to-one" HSCW's.

OIG COMMENT (September 2002): *Interviews with 14 staff members verified that an increase in overtime use had occurred during the summer months. 8 of the 14 spoke of concerns that the situation will reverse itself to resemble the overtime demands of the previous year, which would result in an erosion of the gains made in staff morale. Strategies are in place to diminish the likelihood that overtime use will dramatically increase, but it becomes a distinct possibility in times when funding resources are limited. It will be important for this facility to be able to maintain adequate direct care staffing numbers in order to provide a safe and habilitative environment. Monitoring staff morale during this time is also an important strategy for this facility. This finding remains* ***ACTIVE.***

Status Report: 10/02
Strategies are in place to limit mandatory overtime to that which is absolutely essential to maintain a safe, therapeutic environment. The HSCW positions funded under the budget increase in FY 02 have been maintained despite the current budget reduction. Overtime should remain at significantly lower levels than during the initial IG survey.

Finding 2.4: Review of five charts revealed that there has been considerable gap in access to a psychiatrist.

Recommendation: This gap in access to a psychiatrist should be brought to the attention of the Central Office so that assistance for this situation can be addressed through the state facility medical directors.

DMHMRSAS Response: SWVTC gap in psychiatric services was brought to the attention of the Central Office Medical Director. SWVTC has an addition of contracts for the services of two psychiatrists, services are being provided and clients are seen in a more timely manner. If the situation were to recur, the Central Office will be notified again. With two psychiatrists under contract, a backup should be available even if one of the psychiatrists was unable to provide service.

6 Month Status Report: 07/01/02

The two contract psychiatrists have been coming to SWVTC on a regular basis, there has not been a repetition of the service gap noted during the last IG visit.

OIG COMMENT (September 2002): *Interviews revealed that there had been some changes in the provision of psychiatric coverage by psychiatrist within this facility. This is an important concern and as such was re-noted in the most recent inspection report (OIG SS#68-02). This finding remains* ***ACTIVE***

Status Report: 10/02

The facility continues to attempt to increase the number of on-site psychiatric hours of service. Discussions are on going with several potential providers with the goal to provide at least 16 hours of on-site service per month.

SOUTHWESTERN VIRGINIA TRAINING CENTER
RESPONSE TO SNAPSHOT INSPECTION
September 11, 2002
OIG REPORT #68-02

Finding 1.1: Overall, the facility is clean, comfortable and well maintained.

Recommendation: Continue to maintain this environment in the manner that reflects value in providing a safe and comfortable environment for these residents. Actively address the lack of privacy in Cottage 5C.

DMHMRSAS Response: Environmental and safety rounds will remain in place to ensure that the facility remains a clean, safe and comfortable environment for the residents. Several approaches have been attempted to correct the 5C issue. The facility is now looking at a material that will allow a person to look out the window but blocks view from the outside into the room.

The resident in this room has had a particular dislike of window treatments, to which he responds by taking it down. A behavioral plan to address that behavior is being carried out as part of the individual's program plan.

Finding 1.2: Bars in the showers in the cottages toured present a potential risk to the residents.

Recommendation: Review of the use of this type of bar be conducted by the safety committee and risk management.

DMHMRSAS Response: The Safety Committee and the Risk Manager will review the appropriateness of the current shower rods, explore alternatives and make recommendations to the SWVTC Executive Director. This task is targeted for completion by December 16, 2002.

Finding 2.1: Staffing patterns were noted to be consistent with facility expectations.

Recommendation: Maintain staffing patterns that meet facility expectations for patient safety and therapeutic involvement. Continue to monitor use of overtime and staff morale.

DMHMRSAS Response: Staffing levels and overtime will continue to be monitored on a daily basis. Staffing levels will be maintained at levels that ensure a safe and therapeutic environment.

Finding 2.2: Staff interviewed had a good working knowledge of the contents and application of the new Abuse and Neglect policy.

Recommendation: None. This sampling of staff indicates a good understanding of this essential policy.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

Finding 2.3: The recently hired nurse practitioner has implemented several preventative initiatives within the facility.

Recommendation: None. It will be important for this facility to be able to maintain this key position.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

Finding 2.4: The number of on-site hours of service provided by the psychiatrist per month has decreased.

Recommendation: Central Office review the possibility of utilizing psychiatric staff from SWVMHI or other sources as a part of their job function to provide coverage at this facility until permanent solutions are available.

DMHMRSAS Response: The Medical Director, Office of Health and Quality Care, and Central Office management have been monitoring the psychiatric needs of all Training Centers on an on-going basis. SWVMHI is willing to "share" psychiatric staff whenever its resources allow, but

that has not been possible recently. Various options are being explored. Discussions are underway about shifting psychiatric resources from the mental health facilities to the Training Centers as psychiatric services are moved to the community as part of system re-investment initiative. Availability of other psychiatrists on a part-time basis also is being explored.

SWVTC regularly keeps Central Office informed of changes in psychiatric coverage. SWVTC will continue efforts to increase the number of on-site psychiatric hours of service, with the goal of providing at least 16 hours of on-site service per month.

Finding 2.5: SWVTC would benefit from the addition of a PhD level psychologist.

Recommendation: Review options for securing this position in order to enhance treatment services.

DMMRSAS Response: Such a position is a priority for staffing enhancement at SWVTC. Efforts will continue to fund such a position. One option being explored is transfer of psychologist(s) to SWVTC from a psychiatric facility as part of the current system re-structuring initiative.

Finding 3.1: SWVTC offers a wide array of active treatment activities.

Recommendation: None. Continue to maintain and develop these services.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition of SWVTC's efforts.

WESTERN STATE HOSPITAL
RESPONSE TO SECONDARY INSPECTION REPORT
AUGUST 11, 1999
OIG REPORT # 08-99

Finding 2.3: The Medical Center building was deserted and very institutional in appearance, but was clean and well maintained.

Recommendation: Staff and long-term patients on this unit may want to look at short-term, inexpensive ideas that might give the unit a more domestic appearance.

DMHMRSAS Response: The treatment team on Medical Center will be given this task to address and provide recommendations to the Medical Director by December 1, 1999**.**

6 Month Status Report: 7/1/01
Minor improvements have been made subsequent to this report including posters and more personal items.

OIG Comments *- Interviews revealed that staff did consider ways to make this setting appear less institutional. Minor improvements have been made. The unit still has the pony walls, which limits the decorating options. This finding is ACTIVE.*

6 Month Status Report: 01/01/02
Staff of WSH have utilized artificial flowers, pictures, family pictures of the patients, posters, stuffed animals, seasonal bulletin boards, and calendars in addition to patient art work and crafts to improve the overall appearance of the unit.

OIG Comments- The team toured the unit during the March 2002 inspection and noted that efforts have been made to make the unit appear less institutional by the addition of artwork and personal items. Along with the change in function on this unit, opportunities for increased interaction between the staff and patients are available. It is anticipated that as this unit continues to evolve, additional activities will be added. This finding is **ACTIVE.**

6 Month Status Report: 07/01/02
WSH has appointed a Performance Improvement Team to evaluate ways to improve the interior décor of the wards. This group will also evaluate whether wards can team up with Volunteer groups year round instead of only for holidays. More fully developed recommendations will be due to Administration in October 2002.

OIG Comments- A tour was conducted of the medical center during the December 2002 follow-up inspection, efforts to make this setting appear less institutional were noted. In addition, it was learned that the limited number of evening activities had been added, primarily on the weekends,

for the benefit of the individuals residing on this specialized unit. Interviews with administrative staff indicated that the recommendations from the performance improvement team that was convened had not been presented as of the inspection. This finding remains **ACTIVE** pending the results of this group.

Status Report: 02/28/03
The Therapeutic Environment Performance Improvement team's efforts toward making the Medical Acute Care dayroom more appealing have included the ordering of a new sofa and mini blinds for the windows (dark colored curtains will be removed). In preparation for the new sofa, furniture was rearranged to make color painted walls more visible.

WESTERN STATE HOSPITAL
RESPONSE TO SECONDARY INSPECTION REPORT
February 5-7 & 9, 2001
OIG REPORT # 37-01

Finding 1.2: Nurse Practitioners are not in compliance with Regulations Governing the Licensure of Nurse Practitioners (18 VAC 90-30-10 et seq).

Recommendation 1.2A: NP staff must create a practice protocol consistent with state regulations immediately. NP staff will need to collaborate with IM physician staff in the development of this document. A working draft protocol is requested within one week from receipt of this report (OIG requests a copy of this working draft protocol at 1 week.)

DMHMRSAS Response: With input from the IM physician and the NPs, a draft practice protocol describing NP functions and physician supervision was developed. This draft protocol delineates the services the NP may provide, what procedures the NP may perform, and the mechanisms by which appropriate physician supervision will occur. A copy of the draft protocol is attached (see Attachment C) for review by the Director of Health and Quality Care and the Inspector General. Once a final protocol is approved by these individuals and signed it will be forwarded to the Board of Nursing for final approval. Should the protocol be amended to provide for prescriptive privileges for any NP, the protocol will also be sent to the Board of Nursing.

Key provisions of the NP practice protocol are included or parallel elements of the Medical Care Plan (see Attachment B). Full implementation of the Medical Care Plan requires maintaining the services of two Internal Medicine physicians, which has been problematic. WSH proposes to have a plan for securing consistent Medical Services by May 1, 2001 with full implementation of this plan by July 1, 2001. The Medical Care Plan, in the meantime, will be phased-in with immediate implementation of adequate supervision of the NPs. An Internal Medicine/Family Practice locum tenens will be hired as soon as possible to ensure the services of two physicians are available to directly provide primary care services and oversee the supervision of the NP/PAs. The Medical Director, in the meantime, has begun reviewing the existing resources in the community for medical services. Two reputable Internal Medicine group practices have been contacted to discuss the option of contracting medical services for WSH

6 Month Status Report: 07/01/01
A written protocol was developed and reviewed by the IG, the OAG, and the Board of Medicine and assessed as satisfactory. The IM physicians refused to sign it. One of the IM physicians has subsequently left employment at WSH. The other is currently on annual leave, but has medical evaluations still pending related to his capability of providing supervision. Locum tenens physicians have been employed to provide direct service and provide clinical supervision, but are not able to sign the protocols. A newly hired IM/Psychiatry physician has agreed to participate in the hiring of a replacement for one Nurse Practitioner and will be able to sign the required protocol until a permanent Director of the Primary Care Service is in place.

OIG Comment – *Interviews and a review of documents demonstrated that the facility has developed and approved the protocols for the NP's and PA's. The agreements will be finalized once the physician responsible for oversight of medical services is hired. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02
Protocols for our NP and three PAs have been signed by the supervising physician. The Director of Primary Care will begin work in July, 2002. She will be responsible for the oversight of Medical Services and will finalize these agreements once on duty.

OIG Comment – (December 2002) Interviews with administrative staff revealed that the protocols have been signed. These outline the privileges, responsibilities and supervisory process governing the nurse practitioners. The facility has hired a Director of Medical Services and this individual shares the responsibility for providing supervision of the physician extenders. This finding is INACTIVE.

Finding 1.5: Progress notes written by NP/PA staff were very variable.

Recommendation: The supervising IM physician should regularly review documentation practice with these staff as a component of individual supervision. (OIG would like documentation as to the date this is discussed with supervising IM physician.)

DMHMRSAS RESPONSE: The Medical Care Service utilizes the Medical Care Monitoring instrument (see Attachment E) to review the medical care of patients. This monitor does not specifically address documentation issues or the individual performance of the NP/PA. In collaboration with the NP/PAs and the supervising IM physicians, this form will be revised by April 15, 2001 and implemented for all subsequent monthly reviews. Beginning with the second quarter of this calendar year (April 6, 2001), aggregate findings of the reviews conducted on the care and documentation of the NP/PAs will be forwarded to the Medical Quality Management Committee and the Medical Director for review and discussion. As of April 1, 2001, the current outside physician peer review conducted on the work of the IM physicians will be expanded to include the NPs and PAs. This will allow us to assure that the internal reviews become increasingly accurate as a means of monitoring performance. As an element of the practice protocols for both the NPs and PAs, the results of the monthly internal reviews and the quarterly outside reviews will be provided to individual NPs and PAs. These findings will be reviewed

during required quarterly meetings between the IM physician supervisor and individual NPs and PAs. These findings will be used in the annual performance evaluation process. The Medical Director will meet with the Director of Medical Care Services by April 6, 2001 to discuss this issue and will advise Dr. Everett when the meeting has taken place.

6 Month Status Report: 07/01/01
Progress notes remain variable. Two extenders' notes are adequate to good, two are not yet adequate. One has improved, subsequent to review of the IG report findings. The aggregate data for the second quarter of calendar 2001 has not been presented to Medical PI Committee. The personnel issues complicating the supervision of the extender staff appear to have also complicated extender feedback and compliance with standards.

OIG Comment – *Record reviews continue to indicate variability but the key elements that were previously identified have been improved. It was difficult to track physician sign-off in several of the records reviewed. This is an evolving process and should become more standardized and consistent following the hiring of the new director of medical services. This finding is ACTIVE.*

6 Month Status Report: 07/01/02
WSH continues to monitor for improvement. Most recent two quarters of peer review data demonstrate continuing improvement. All notes written by the NP and PAs are now reviewed by an MD via a carbon copy system initiated this past year. In addition, as noted in previous status areas the Director of Primary Care will begin employment on July 10, 2002 and will have responsibility for continuing improvement in this area.

OIG Comment – ***During the December 2002 inspection, five records that involved documentation by the physician extenders were reviewed. All of the records contained documentation that included elements previously identified as essential such as evidence of the completion of physical examinations and follow-up. Interviews with administrative staff indicated that the supervision of clinical notes competed by NP and PA staff is occurring and maintained in an administrative file in the assigned supervisor's office. In addition, case reviews are completed during at least weekly supervision groups. As a system has been established for clinical review to occur on a regular and consistent basis, this finding is*** *INACTIVE.*

Finding 1.6: The role that attending psychiatrists have in co-signing orders written by NP/PA perpetuates unclear physician supervision.

Recommendation: Any formal relationship between the attending psychiatrist and NP/PA will need to be addressed as a component of the protocols developed by NP and PA staff. (OIG will be reviewing these protocols per Finding 1.1 and 1.2)

DMHMRSAS RESPONSE: As derived from the medical care plan and the draft practice protocols, the relationship between the attending psychiatrist and the assigned NP or PA is

collaborative rather than supervisory. Orders written by the NP or Pas, beyond the scope of what they may order within these agreements, will be signed by one of the IM physicians upon implementation of the plan.

6 Month Status Report: 07/01/01
The protocols are developed, but not signed. Orders continue to be signed by the psychiatrists, in most cases, due to the absence of signed protocols and full-time IM physician issues. Locum tenens physicians provide clinical supervision regarding cases, but are not able to sign protocols or orders in the absence of such agreements. The need for a Director of Primary Care Services is an essential issue and is discussed above.

6 Month Status Report: 01/01/02
The psychiatrist remains responsible for the overall care of the patient while the Primary Care Service is responsible for medical problems referred to them. This is stated in the protocols. NPs and PAs have been granted privileges to write independent orders for routine diagnostic tests and over-the-counter medications. One PA and the newly hired primary care physician are assigned the Admissions wards of the hospital. This PA's orders are now counter-signed by the Primary Care physician. The orders of other NP/PAs continue to be signed, at times, by the psychiatrists. This will end when the second full time Primary Care physician (and Service Director) is hired. This position is currently in the interview stage. Once the second permanent Primary Care physician is hired, the NP/PAs will move to having expanded prescriptive authority, via their agreements with the Primary Care MDs, and the supervising Primary Care physician will counter-sign orders that the NP/PA is not authorized to prescribe.

OIG Comment – Interviews indicate that the assignment system between medical and psychiatrist staff continues to be negotiated. This finding will remain ACTIVE.

6 Month Status Report: 07/01/02
With the changes implemented in the primary care system and the changes in personnel the communication problems that used to exist have been resolved. The Director of Primary Care begins work in July, 2002 and over the course of the next quarter will address the signing of orders by the NP and PAs that are beyond their privileges.

OIG Comment – *(December 2002) Interviews with administrative staff revealed that with the completion of the protocols, lines of supervision have been clearly communicated and implemented. Attending psychiatrists continue to review the clinical case and sign off on having reviewed the involvement of the physician extenders with the patients but this review has a very different function than noted in the past. Increased open communication between the attending psychiatrist and the primary care providers has eliminated some of the problems in identifying and coordinating patient care responsibilities. This finding is* ***INACTIVE.***

Finding 2.2: IM physician staff rarely recommend specific follow up when seeing patients.

Recommendation: The quality of medical care would be enhanced with more detailed recommendations regarding follow up. The follow up instruction could recommend: 1) "no specific follow up necessary"; 2) follow up with NP/PA within a certain time frame; or 3) follow up with MD within a certain time frame. (OIG will either return to audit or request chart information in the future.)

DMHMRSAS Response: Included in the physician responsibilities in the practice protocols for the NPs and PAs is the requirement that the IM physician specify "the indications and/or intervals" in which a patient must be seen again by the IM physician. This language was added to the medical care plan and an element was added to the Internal Medicine physician peer review instrument to specifically monitor for this requirement. (see Attachment G). The expectation that physician and/or NP/PA follow-up be specified when a patient is evaluated will be discussed with the Director of Medical Care Services by April 6, 2001. As the supervisor for the Medical Care Service he will be informed of the IG's intention to request a chart audit in the future.

6 Month Status Report: 07/01/01
Chart reviews by the Medical Director indicate that required follow up is more consistently documented. Formal aggregate peer review data from the second quarter of calendar 2001 has not been presented to Medical PI Committee.

6 Month Status Report: 01/01/02
External peer review for October to December 2001 is pending. For July through September 2001, a significant deficit was still evident: only 35% of cases seen by the Primary Care physicians had a specific follow-up described. These physicians have now changed, and the Medical Director has reiterated this expectation. The changes in the service organization in which the primary care service is responsible for medical problems referred to them greatly attenuates the prior situation.

OIG Comment – Implementation of an auditing system demonstrates that the facility administration is focusing on the quality improvement of the documentation of follow-up. The follow-up review revealed improvement but this remained below the quality standard established by the facility. This finding remains **ACTIVE.**

6 Month Status Report: 7/1/02
WSH reports that for the most recent quarter reviewed (Jan-March, 2002) all primary care physician evaluations documented the necessary follow up. Further, all NP and PA work is now reviewed by one of these physicians to assure, among other things, that the appropriate evaluation and follow up are specified.

OIG Comment ***–(December 2002) Interviews with administrative staff and record reviews demonstrated an increased focus on outlining recommendations for follow-up for patients seen by the primary care providers. Plans were in place and follow-up occurred as outlined in seven of the nine records reviewed. Future reviews will involve tracking the involvement of primary care providers. For the purposes of this finding the evidence was adequate for making this INACTIVE.***

Finding 2.8: Staff interviewed identified an on-going history of unclear lines of accountability between medical services and psychiatric services.

Recommendation: No specific recommendation for this finding.

DMHMRSAS Response: DMHMRSAS Concurs.

6 Month Status Report: 07/01/01
WSH looks forward to the hire of the Director of Primary Care Services who will work closely with the Facility Medical Director to identify accountability strategies for these two service areas.

6 Month Status Report: 01/01/02
This issue has been addressed by means of the multiple changes in how primary care is provided, changes in personnel, the specifications outlined in the NP/PA protocols, and the specifications made in hospital policy.

OIG Comment – *Interviews and record reviews as well as the changes that have occurred in the provision of medical services within the facility have provided for a system of increased and clearer accountability between the two service divisions of physicians. The facility has identified several remaining items that still need to be established, such as the hiring of the Director of Medical Services before this issue is fully resolved. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
The WSH Medical Director has clarified, by policy, the responsibilities related to patient care for these two groups of physicians. With the changes in the primary care system, associated prior personnel problems with communication and confusion about responsibilities for individual patients have not been reported.

OIG Comment *– (December 2002) Interviews and record reviews indicated that problems with unclear lines of accountability between the medical and psychiatric services have been remedied. Policy and Procedures as well as the Medical Care plan provide guidance within the organization on the roles and responsibilities of these services. The current configuration of personnel has made great strides in assuring that both the physical and mental health needs of the patients are addressed. This finding is* ***INACTIVE.***

WESTERN STATE HOSPITAL
SNAPSHOT INSPECTION REPORT
MARCH 7, 2002
OIG REPORT #57-02

Finding 1.1: Overall the facility was clean and well maintained.

Recommendation: Continue efforts to make this very institutional setting more comfortable.

DMHMRSAS Response: We will appoint a Performance Improvement Team to make fiscally responsible recommendations to improve the attractiveness of the ward settings, including patient bedrooms, visitor's rooms, and common areas. Draft recommendations will be available by July 1, 2002 for Executive Staff review and the development of implementation plans. Depending on the nature of the recommendations we would expect to have completed the first phase by October 1, 2002.

6 Month Status Report: 07/01/02
Because of the facilities focus on Department of Justice site visits the Performance Improvement Team draft recommendations will not have recommendations available until October 1, 2002. As that time based upon fiscal responsibility project phases will be delineated.

OIG Comment: (December 12, 2002) *Interviews with administrative staff indicated that the results of work completed by the performance improvement have not been finalized at the time of this follow-up inspection. In addition, several observations of unsanitary conditions were noted during the same visit, (Refer to Finding 3.1 in WSH Reprot #72-02). This finding remains ACTIVE.*

Status Report: 02/28/03
The PI Team continues to work toward obtaining suitable bulletin boards for patient bedrooms that do not present hanging hazards. Expect to have this completed by May 2003. The hospital has allotted $3,000 for the purchase of posters and completion of the bulletin boards. Hospital physical plant services will build non-hazard frames as resources allow. Residual funds will be put toward the purchase of artificial plants.

Finding 2.5: Facility administration is developing a plan to make routine medical care available in the actual psychosocial treatment mall so as a minimize disruption to treatment.

Recommendation: Incorporate this service as planned.

DMHMRSAS Response: This is an integral part of our overall restructuring of both the Medical Care service and our Transportation/Escort services. The newly hired Director, Primary Care services, arrives July 8, 2002, and this will be one of her first projects. WSH expects to have the services fully operational by October 1, 2002. The Primary Care Services staff will be encouraged to use the examination rooms proximal to the PSR treatment areas in the interim.

6 Month Status Report: 07/01/02
The Director of Primary Care Services is anticipated to be on duty at WSH beginning July 10, 2002. It is still anticipated that routine medical care will be provided in the Psychosocial Treatment Mall by October 2002.

OIG Comment: (December 12, 2002) *With the relatively recent hiring of a Director of Medial Services at he facility, other initiatives took priority over the completion of this additional component of medical care however effort are still underway to establish routine medical care as part of the psychosocial treatment mall. This finding remains ACTIVE.*

Status Report: 02/28/03
In joint collaboration between the Medical Director, the Director of Primary Care Services, the Primary Care Team, and the PSR staff, it was determined, after a trial, that providing these routine services in the Stribling Building was not a good plan. It was found that examinations for problems that arise during the PSR program time period require fairly simple evaluations, but that most routine matters are best handled on the ward before or after PSR or within the Medical Clinic if more extensive evaluation is necessary.

WESTERN STATE HOSPITAL
SNAPSHOT INSPECTION REPORT
DECEMBER 3-4, 2002
OIG REPORT #72-02

Finding 1.1: There were adequate numbers of staff present to safely and appropriately supervise the patients during the evening shift tour.

Recommendation: None. Staffing patterns were consistent with facility expectation during the evening shift when unit tours were conducted.

DMHMRSAS Response: DMHMRSAS appreciates recognition of WSH's accomplishment in staffing evening shift appropriately.

Finding 2.1: Western State Hospital provides an array of active treatment options for patients in a variety of treatment mall settings, depending on each patient's level of functioning and stability.

Recommendation: None. This facility has an established process for reviewing and updating active treatment programming that is based on consumer needs.

DMHMRSAS Response: DMHMRSAS appreciates recognition of WSH's review process for updating active treatment programming.

Finding 3.1: Unsanitary conditions were noted in 7 out of the 12 bathrooms inspected as well as one seclusion room.

Recommendation: Have members of Buildings and Grounds conduct inspections of the bathroom to determine whether the equipment for the automatic flushing of toilets is functioning properly. Timely cleaning of the seclusion rooms following use needs to occur.

DMHMRSAS Response: A number of actions have been, or will be, taken to improve the cited sanitation conditions. WSH Physical Plant Services will complete a thorough review of all automatic flushing toilets by March 1, 2003. All ordinary problems will be addressed as part of this review. Should there be major operational problems that require unit replacement resulting in high cost, WSH Executive Staff will discuss these and develop an action plan by April 1, 2003.

In addition, the findings of the Inspector General have been shared with unit staff. Nursing Staff has already sent a reminder to all unit staff regarding ongoing maintenance of cleanliness for the seclusion rooms. Housekeeping staff will check each seclusion room at the beginning of their workday and will correct any sanitation problem found. This expectation has been communicated to housekeeping staff.

Finding 4.1: Western State Hospital utilizes behavioral programming both on the unit management level and in the formation of individualized behavioral therapy plan, as clinically indicated.

Recommendation: Review opportunities for expanding, as appropriate, the expertise of this team into community settings as an additional tool for assisting patients make a successful transition into community-based services.

DMHMRSAS Response: DMHMRSAS appreciates recognition of the fine work done by the Behavioral Consultation Team (BCT) at WSH. The BCT will modify its current referral form to explicitly include the opportunity for consultation related to transitional/ discharge planning. The BCT will respond to consultation requests from CSB psychologists or other appropriate staff within resource capacity. Our Community Services Director will make CSBs aware of this resource. Community staff will be allowed to attend training in behavioral knowledge/competence conducted at WSH.